Wednesday, 20 November 2024

(10.00 am)

LADY HALLETT: Ms Carey.

MS CAREY: Good morning. My Lady, the first witness today is Mr Vaughan Gething. He is appearing via video link and he will affirm.

LADY HALLETT: Thank you.

MR VAUGHAN GETHING (affirmed)

Questions from LEAD COUNSEL TO THE INQUIRY for MODULE 3

LADY HALLETT: Mr Gething, thank you for coming back to help us again.

THE WITNESS: Bore da, my Lady.

MS CAREY: Mr Gething, good morning. We have a number of topics to cover this morning. I hope you have in front you a copy of your statement, INQ000474252, to which we will be going at various points in the evidence.

May I start with some background. I think you are a lawyer by background. First became a member of the Senedd in May 2011, and five years later, in May 2016, became the Cabinet Secretary for Health, Well-being and Sport, which in due course became the Minister for Health and Social Services; is that correct?

A. That is correct.

Q. And you remained the minister I think until 13 May 2021?

A. That's correct.

Q. In your role as minister, there are responsibilities set out at length in your statement. I'm not going to go through them all, but is it right that in October 2020 your ministerial responsibilities were added to to include the Covid response, screening, vaccination and some other responsibilities?

A. That's correct, that formalised what was in practice happening.

Q. Quite. All right. And you are there to set the policy and strategy and, to use your words, hold NHS leaders to account?

A. Correct.

Q. Now we know that in Wales you discharged your statutory duty by delegating that to a number of the NHS bodies including the local health boards who are responsible for the operational decisions; is that correct?

A. Correct.

Q. All right. And we've heard from Dr Goodall about the power to issue directions, which, as we understand it, are mandatory, but he told us they were mainly financial; is that correct?

A. Correct.

Q. Can I ask you, please, you say in your statement that in April and May 2020, you met with NHS chairs and chief executives to hear about the challenges. Can you

help us, please, with some examples of the things that they were telling you.

A. So there were a number of things, both about how they'd had to re-organise services to ensure the service didn't become overwhelmed. You'll recall I made a statement on 13 March, so some of it was about what had happened since then. A lot of it was about the current situation. So that's not in terms of operationally what they were doing but a large part of their concern was about staff, staff welfare and well-being and what was coming next. Because we still didn't know a great deal at that time so people were living with fear, both in the wider public and indeed in our health and social care services.

Q. You say in your statement that you feel you had sufficient understanding and knowledge of the challenges facing the NHS. Clearly those meetings were no doubt a part of that. How else did you gain that understanding?

A. Well, in addition to the concerns that chairs and chief execs had and the conversations I had with Dr Goodall, I had conversations with Dr Atherton, I had conversations with the chief nurse and the Chief Scientific Adviser for Health, the royal colleges, including the Academy of Royal Colleges and trade

unions, including the RCN and other trade unions in partnership. So issues that we may go on to around PPE for example, around what was happening with testing, those were things that came up in all of those different fora from a slightly different perspective. And, you know, anecdotes about operational practice.

So trade unions would sometimes raise issues where they felt that they weren't getting a sensible hearing from the employer and so some of that was about making sure those issues were resolved. And often they were issues that just needed people to have the same conversation at the same time, so -- and there are big strategic issues, and sometimes you can get drawn into what seemed like minor issues but I think are important about delivering trust.

Q. Could you give us an example of a minor issue that you got drawn into?

A. Well, they were sometimes just about individual workplace practice and about whether people who were running the organisation and the -- so the impact of that on their staff. So Unite and UNISON raised as examples. I gave an example in my statement actually about where a union had an issue at the Welsh Blood Service, where actually the issue about members of the Welsh Blood Service not using their gloves all the time

was actually what their members felt they should do. And that was something where you wouldn't normally have expected the minister in the middle of a pandemic to get engaged in that, but that was about a feeling of trust and people being listened to, and sometimes if you don't deal with those they can accelerate and become a much bigger issue.

Q. I think you also held monthly meetings with the Welsh ambulance service trust, because in both pre and during the pandemic, clearly there was a pressure on the flow through emergency departments?

A. That's correct. I had -- since I became the cabinet minister, I'd held meetings through the winter to understand both before winter where we were, in the winter and then towards the end, because that is a time of extraordinary pressure. I know every year people say there aren't points of pressure, it's year round, but every winter there are even more extraordinary pressures, and the ambulance service really were on the front lines throughout the pandemic.

Q. I think you are aware that the Royal College of Emergency Medicine have provided the Inquiry with a statement, and there was what is said to be an absence of meetings between either yourself and the Welsh Government with the Royal College of Emergency Medicine.

Can you help, Mr Gething, as to why you didn't meet with that Royal College?

A. Well, I had meetings for a purpose, as did my officials, and I do think it's worth pointing out is we had a clinical lead on emergency medicine, who at the start of the pandemic was also the vice president of the Royal College of Emergency Medicine Wales. The meetings with the Academy of Royal Colleges included the Royal College of Emergency Medicine. I think we had evidence from Frank Atherton about his meetings with the Academy of Royal Colleges as well, again including the Royal College of Emergency Medicine.

I don't ever recall receiving a meeting request from the college to discuss a particular issue, whereas, for example, when I met the Royal College of Surgeons, they had a specific request about wanting to restart elective activity but to do it in a way that took account of where we were.

Q. May I ask you briefly about control and command structures.

UNIDENTIFED SPEAKER: Sorry, my Lady, we have lost the --

MS CAREY: My Lady, I have lost Mr Gething on my screen.

LADY HALLETT: Oh, I can see him there.

MS CAREY: It may be that both -- all of counsel's rows --

LADY HALLETT: Can the public gallery see him?

(Technical problems)

MS CAREY: We can hear you but we just can't see you on everyone's screen.

LADY HALLETT: Is there any way we can find out if those following on YouTube can -- because if people at home watching online can follow, we could probably carry on, if people will forgive us.

MS CAREY: You are back now.

Can you see and hear me all right?

THE WITNESS: I can indeed.

LADY HALLETT: Sorry about that, Mr Gething. Technology is wonderful when it works.

THE WITNESS: Indeed, indeed, dim problem.

MS CAREY: I think we were just dealing with the other meetings you had in the absence, you say, of a particular request from the Royal College of Emergency Medicine, and I was moving on to command and control structures; all right?

A. Yes.

Q. The Chief Medical Officer for Wales has commented that even when he came into post in 2016 there was a report which suggested there was "insufficient ability to have a command and control arrangement within Wales", and he said that had "bubbled around ever since" and "it was

certainly a feature when Covid hit us."

Mr Atherton went on to say that although he was not critical of the NHS executives, he thought in fact there needed to be a stronger guiding hand and a move away perhaps during a pandemic from the collaborative approach to a more directive approach.

And can I ask you, Mr Gething, do you agree that there was insufficient ability to have a command and control strategy sufficiently directive?

A. Well, the problem is this is one of those challenges in running a whole system, so you can't make every decision from an office in Cardiff Bay but the reason why the NHS Executive for Wales was formed was to have a more central approach. And this was often, actually, about service change and transformation, which is actually extraordinarily difficult and you always get people arguing against local service change because they fear the loss of something rather than demanding service change because a better service could be delivered if only you'd re-organise it.

So it was really more in that sense. And when the pandemic came the collaboration and the directives that came, the Welsh Government made a whole series of choices and convening that it wouldn't have done in normal times.

I'm sure there are lessons to learn about areas where we might have wanted to be even more directive but I think the main lessons are likely things we would want to do differently.

Q. All right. Can I ask you potentially about an area you may be more directive. By the end of March 2020, the waiting lists for non-urgent elective care were higher than they had been the previous year, and inevitably you knew were going to increase because of the decision to suspend non-urgent elective care. One of the experts in the Inquiry, the hips experts, said that delay obviously in restarting surgery had resulted in not only the pain and disability but for some people a real reduction in their quality of life and waiting times now in Wales are consistently over two years, and they made this observation, that whilst there was the decision taken to cease elective care, there was no top-down mandate or direction in Wales about how the trusts and boards should restart routine elective surgery.

Was any thought given to directing the boards to resume a percentage of their pre-pandemic non-Covid work?

A. Well, the frameworks that were issued, the operating frameworks that were issued after the first wave were actually about getting elective care restarted. I know

they are covered in my statement and in Dr Goodall's, so actually those were directions issued about having an operating framework. The challenge was we issued those frameworks when broadly the situation was much better than the first wave and then everything got substantial worse through the autumn and the winter.

And the challenge always, and this comes back to why, when you talk about service reform you're dealing with inconsistency in delivery. You're dealing with very local models of care and how you get greater consistency and efficiency and, with respect, I don't think those things are linked to the pandemic. I think those things are about a more general challenge in delivering health service transformation and reform as opposed to the choices we made directly in the pandemic.

Q. The quality frameworks of which you speak did obviously urge the boards to restart but it never said to them: do 50% this month, 60% next month, or add 100 every month, and I think what the experts were saying is it perhaps needed that particular direction being given to them to help encourage, if not enforce, the resumption of non-urgent elective care.

That's the point I'm getting at.

A. I'm not sure that works in practice. If you want to -- for example, think of the evidence of Phil Kloer and

Glangwili hospital and the networks they had there, and compare that to the evidence of Professors Walker and Jenny in UHW, you're operating in quite different contexts.

Q. Yes.

A. And if you have a surgical team of six people and three of them are on the vulnerable, and the clinically vulnerable list, telling them they nevertheless need to get 60% efficiency isn't realistic, so that's part of the challenge in understanding the different centres you have, how they operate, and the context, and that's why health boards are responsible for delivering those operational choices. Nobody wants to under-deliver on performance in this area because in normal times you understand people live with discomfort if they don't receive potentially life-changing treatment. Even more so given what happened in the pandemic.

Q. Can I ask you this then. What did do you as minister to ensure -- forget a lack of percentage or a direction that they must X thousand operations per month -- what did you do to ensure that they were actually fulfilling the advice and direction you'd given them to restart it and restart it as soon as they were practically able to?

A. Well, after the frameworks were issued you still have the regular meetings with chairs and chief execs and we

did discuss what they would do on restarting that activity. The problem is after we issued the frameworks, Covid started to rise significantly, so our ability to restart the non-Covid part of it actually gets more compromised but by then, and again you see this in the evidence of Phil Kloer and the respective medical directors for Cardiff and Vale Health Board and others, you are starting to see the ability to try and have segregated red and green lanes as well. So you're trying -- and this, again, was something the Royal College of Surgeons urged to try to have a green zone, where you can try and undertake this more elective activity with the backlog that we know is building up, and a red zone where you know, actually, you have to take more precautions and that means your efficiency is compromised.

Q. Can I ask you this, do you think that in a future pandemic there should be contingency plans which include a strategy or a plan, call it what you will, for either the continuation of elective care or at least the prompt recovery of it?

A. I think it's helpful to try to learn lessons from what worked well here and what didn't and the challenges you have to go back to, what's the scale of your challenge at the start, how can you then operate safely in

elective areas, an (inaudible) pandemic might not be this one. The challenge of having enough testing and understanding how you operate safely and the estate we have are things at the time, but to understand how we got to restart at this point and what we might do better, I think is definitely well worth learning and try to understand how we don't simply accept there'll be a very large backlog and there is nothing we can do about it.

Q. Can I ask you then about some of the challenges. In your paragraph 58 you make the observation that your primary focus was to safe lives and protect the NHS. And can I ask you, what did you mean by the phrase "Protect the NHS"? It's your paragraph 58, Mr Gething.

A. I think we're really talking about, and this does go back to, I gave this evidence in Module 2B as well, what had happened in northern Italy really affected me, a first world country with a first world healthcare system that was plainly overwhelmed, with people lying in corridors in a way where the care was neither dignified nor appropriate, and that really bothered me. How do you make sure that doesn't happen? It isn't just about those individuals, I think they'd have a much wider shock and impact in wider society outside the health service as well. So I was always concerned to

make sure that the NHS didn't get overwhelmed in that way and that meant that we had to turn off parts of the NHS for that to happen. None of that is comfortable and none of that is harm free, but a much greater harm would have been what we saw in northern Italy.

Q. What did you understand the NHS overwhelm would look like? No more beds? No more ICU beds? No GP appointments? What did it mean to you?

A. Well, I thought it could mean everything that we'd seen on our screens. And it's hard to overstate how shocking some of the predictions were about what might happen. If you really can't have intensive care beds, if you really have people who need and would benefit from invasive ventilation and you can't do it, then, you know, more people dying than potentially need to and they die in a very undignified and harmful way itself as well, and that then has a ripple into every other part of the service.

If you look at what we did, there was a ripple into every part of the service as well. If your main part in the hospital system can't cope and is overwhelmed in that way, that ripple is even more significant and we'd have lost more lives from the public and from our staff as well, if that had happened.

Q. So do I understand you correctly to -- do I understand

this correctly that, for you, if someone didn't get an intensive care bed or wasn't able to be put on a ventilator, that would be an indication that the NHS in Wales was overwhelmed?

A. It's an indication that it's being overwhelmed. In more times you have challenges on staff ratios and some services and they're operating under some stress. What you'd have seen if the whole service was overwhelmed was that you'd have seen large numbers of people not being able to get appropriate care, including people where the NHS could and should be able to act to save their lives. Now, that was the nightmare scenario because actually the harm done to staff who were going into work in those situations would be even more significant than the harm that we know that our staff are living with now from what did happen.

Q. We'll come on to look on the impact on staff in a moment, but can I ask you this. Do you consider that during your tenure as minister, the health system in Wales became overwhelmed at any point?

A. No, but that's only because we took extraordinary measures. If we'd tried to run the system as normal then it would have been overwhelmed. That's why we had to take a measured process to turn off parts of the service, we needed to change it to allow the service to

still function, and in particular those people with extraordinary need that we saw in both waves 1 and 2.

Q. Can we have a look at some of those measures during the course of the next part of your evidence.

And can I start with the framework that you published on 13 March and perhaps if we could have a look at your paragraphs 108 and 109 in your statement, Mr Gething.

Can we have on screen, please, INQ000474242_32.

If it helps you, Mr Gething, we have them on the screen.

The framework there was published at 4 o'clock on 13 March. It set out a number of recommendations for action which included the suspension of non-urgent care, the prioritisation of using non-emergency patient transport services, to focus on discharge, expedition of discharge of vulnerable patients, and a number of other measures that we're familiar with to all try and plan for what was thought to be coming down the track.

Is that it in a nutshell?

A. Indeed. That shaped just some of what was happening.

Q. Can I ask you this, why was this framework not made as part of a direction but was, in fact, just essentially recommendations for local health boards as to how to respond?

A. I think that underplays the significance of doing this in any event. We had a real discussion about whether I should simply direct people to do this or whether it was preferable to issue a framework to allow this to happen and that, again, comes back to the different contexts that health boards are operating in.

Again, I know Phil Kloer indicated that in West Wales the pandemic arrived a little later than in East Wales, for example, so the measures taken in different health boards were different but also, if you look at North Wales -- north-east Wales and north-west Wales, they'd have needed to do different things to get ready for what was happening and that was in the same health board.

Q. All right.

A. So there was a real discussion and consideration of it, but issuing the framework in itself was an extraordinary measure. This is announcing that standard parts to the health service are going to be turned off and that is not a usual thing to do. I remember the press conference in announcing this and just getting the dawning realisation of how significant this is going to be.

Q. I follow that. You don't want, for example, a West Wales hospital that hasn't been hit yet

suspending elective care before they absolutely need to. So is that an example, you would say, of why you don't make it directive but you gave this as a framework as opposed to a mandatory order to the boards?

A. Correct. The situation in West Wales would be very different from Gwent, very different to Gwynedd, so if you have a one-size-fits-all, then you know you'll make things worse in some parts of the service where you don't need to.

Q. Now, the briefing that underpinned the announcement of the framework, included, did it not, a reasonable worst-case scenario that critical care capacity simply was not going to match the level of critical care that was likely to be required in Wales?

A. Yes, that was one of the very difficult things. At that point, the modelling was on behavioural science and the expected response of the public, so yes, it was a moment of very real concern for everyone across the healthcare system.

Q. I think briefings -- well, the reasonable worst-case scenarios varied, clearly, but at one stage it was suggested that there needed to be a 30-fold increase in critical care beds in Wales and I think, in due course the reasonable worst-case scenario in April reduced that to 900 ICU beds required in Wales and you had, I think

you say in your statement, 145 level 3 critical care beds?

A. I can't recall exactly. But I think there's the adult beds with some for children but, yes, nothing like what we're told we might get.

Q. Do you consider that entering the pandemic with high bed occupancy and fewer critical care beds for the size of the population in Wales meant that the Welsh hospitals had to surge all the more and put them under even more strain?

A. There was a huge surge that was potentially required. And if you then go back to the pre-pandemic healthcare system, and I think there's quite a lot about wanting more capacity in more areas and our bed numbers compared to European comparators including on critical care, but that requires investment over a longer period of time not just in staff but in the physical layout of your hospital buildings as well. So it did leave us with greater vulnerability than if we were in better position. I think that's undeniable.

Q. I think Dr Goodall told us that pre-pandemic occupancy was regularly around 100%?

A. Correct.

Q. All right. How did you ensure that there was going to be sufficient critical care capacity given the vast

increase in critical care beds that were needed, whichever reasonable worst-case scenario you look at?

A. That was partly the reason for the framework. If you're going -- and at that point we thought the peak would come later and I think I said this in my statement, as in others, about a single peak was expected and we thought we were a good deal more weeks away from the peak than we were in fact. So, actually, if you don't take an approach to try to manage reducing other activity in your system, you can't redeploy your staff, retrain them, and actually get all the resources in place that you need. So there had started to be anecdotal calls from different people but also, and this goes back to some of your earlier questions about chairs, chief execs, and engaging with them, a realisation that we actually need to do something that is more significant than sending a couple of people on a training course.

Q. The framework, though, did not provide a model or an estimate of the number of beds that you were looking to free up or that would be required, did it?

A. No, because again that would have been us trying to numerically manage things in a way that would have been artificial but it was about, you've got to turn off lots of this activity to be able to have a plan about how you

then retrain people as well, and that was more apparent in, if you like, the three south-east health boards, so Cwm Taf Morgannwg, Aneurin Bevan, and Cardiff and Vale, because they were -- by 13 March, that's where we were starting to see numbers coming that we were anticipating to come in, so actually they were much more interested in how quickly they could flex, but also, because of the hospital infrastructure in those areas as well, with UHW being the biggest hospital in the country by a long way as well.

Q. Can I ask you this, if you're going into the pandemic with 145 ICU beds and you know that the modelling says you need 900, how were you going to get that surge if you don't tell the boards: we need another 750 beds? You need to provide 100, Cardiff, you need to provide 100, Morgannwg, et cetera, et cetera, how were you going to ensure you were going to get the 900 if you don't tell them you've got double your capacity or triple it, or you have got to provide another 100 beds?

A. Well, actually, the planning assumptions around that weren't in the framework but those conversations were taking place between Dr Goodall and the system and the system in itself. So the critical care network in Wales wasn't unaware of the reasonable scenario assumptions, and that's part of the reason why lots of people engaged

in critical care were actually saying you need to do something and do it earlier rather than later to give us the capacity to flex up for what might be coming.

So, you know, and I'm sure it's in Dr Goodall's evidence and in Judith Paget's evidence as well, because she was the chief exec of Aneurin Health Board at the time we are talking about, about the way in which they understood need to flex up and to build up their capacity in this area and that meant you have to turn it off somewhere else to have the bed stock available and, crucially, the staff available to deliver the care.

I think the other point about the reasonable worst-case scenario, of course, is that that is a reasonable worst-case scenario if all of your other measures don't work and that's the challenge, I think, about your planning assumptions and not being able to assume that everything will work, and what the sort of public response is for something we haven't had to live through before.

Q. What I wanted to try and understand, though, was how you were satisfied there was going to be sufficient critical care capacity. I understand Dr Goodall is having these conversations but you, as minister with overall responsibility, how did you know, don't worry, we're going to have enough beds, if the reasonable worst-case

scenario comes to fruition?

A. Well, there are two things. The first is in normal times I have regular contact with Dr Goodall as the chief exec of NHS Wales and director general. In the pandemic that's then daily contact about what's happening so there are regular conversations between -- and this is part of it.

The second thing is, the honest truth is that no one can give you the direct assurance that we can have 900 critical care beds in place by a certain point in time. All of your planning and your assumptions are about how you maximise what's possible but it's dishonest to say I was assured we would have 900 critical care beds in place by the start of May because there are so many moving parts and that's partly the worry in making choices. But even if you make the best possible choice available to you, it's still possible that you could live through the disaster you're trying to avoid.

Q. Did you get any updates as to how the capacity increase was going? Did they say to you, for example, we're two weeks now on from the framework, we've got 100 extra beds, or 200, or whatever the figure was?

A. Yes, I think you've seen some of Dr Goodall's updates that he provided to me, the daily updates, so that does

show that not only was there a daily conversation with him, but I'd look at those sort of figures each day to see what were they reflecting, what was coming through the door, what capacity is being created, and so that is happening in realtime.

I'm sure the Inquiry has available to it all the data and I think they just had examples of it but there is a regular conversation, if not a daily one, between myself and Dr Goodall. I saw more of him than my wife on most days.

Q. We have more data than we need on those days, I suspect, so I hear you there.

Can I ask you this, you say this in your statement that at no point during the pandemic were bed capacity limits breached in Wales, the highest overall occupancy rate during your tenure was 86% during September 2020. This included critical care beds, acute beds, field hospitals, private hospitals, community hospital beds but additional surge capacity remained available. Reporting, as I understand it, though, is done nationally. Do you know what the position was in any given health board as to how close or otherwise they were to being full?

A. Yes, I think I have set this out in my statement. Cwm Taf Morgannwg did get really full and that shouldn't

really be a surprise because when you think about the hospital estate but also it's the health board in Wales with the largest concentration of least advantaged communities. We know Covid didn't strike communities evenly. So, actually, there was real worry. So there was mutual aid moved around, as well, but that also goes into harm, I'm sure we'll discuss later on, for staff of what they're seeing and what they're doing.

And the statement that we didn't breach capacity is true but it comes at a cost because you had to turn off other parts of the service and, again, it looks different in different parts of Wales. I think Phil Kloer said that they never had to move away from 1:1 ratios in intensive care, whereas a statement from the medical director in Cardiff said that those were stretched, and I know that Professor White has indicated that too. So there is capacity, there is a bed available, but actually your resources are significantly stretched and redeployed.

Q. A number of things there, please, Mr Gething. You mentioned Cwm Taf. I think you say in your statement that Prince Charles hospital in Cwm Taf came close to declaring CRITCON 4 as they had exhausted all their capacity but there was still limited capacity in neighbouring local health boards. Were you informed of

how close Cwm Taf came to the brink? Is that information you get?

A. Yes. Both from Dr Goodall but also I'm sure it was mentioned by Frank and his deputy Chris Jones, because they were close to the system as well. So the system in Wales is fairly small and that means that relationships with chairs and chief execs and the staff around, it isn't, if you like, the arm's length way that England is managed because it's a much bigger unit.

Q. Different size. Understood.

Now, you also mentioned in there though references to the ratios and, you're right, Mr Kloer gave evidence that they didn't breach the 1:1 ratio, University Hospital of Wales said this:

"During the first and second waves ICU nurses frequently worked outside the usual ratio at a ratio of 1:2 or above. In wave 2 there was very limited support staff available to assist."

In fact they had lost the number of staff from the first wave which obviously placed demands on them, and they say this:

"Very few patients were transferred to other critical care units. Unlike in English, Wales' Critical Care Network is not an operational network. Although they had meetings where they were over

capacity they primarily managed at that hospital through dilution of nursing ratios run through transfers out through the whole period in question."

Can you help me, what were you made aware of about the state of critical care transfers between either boards or intraboard during the course of wave 1?

A. So I didn't have a report that said: here are the number of transfers that have taken place. It was a more general: here is what we're doing and how we're coping and this is what we're doing and having conversations between staff. So I knew the Critical Care Network would discuss things within its board but also across Wales as well, and that's the point about mutual aid. It isn't a managed central network but it is nevertheless a network of people who understand the pressures other people are coping with.

If Cardiff and Vale, for example, had wanted to transfer patients and ask mutual aid then they could have done that and they would have understood how to do that. It's about how you cope. And that's one of the things I think is really important, it's about how you cope with what is taking place around you, and the various health boards have set out how they did that.

Q. If the ratios are stretched, though, 1:2 or above, as they were at the University Hospital of Wales, do you

agree, Mr Gething, that it is likely people were getting less than optimal care than they would have done pre-pandemic times?

A. I can't honestly tell you that that definitely did or definitely didn't happen, because in terms of the outcomes, and outcomes that you'd have expected, I haven't looked at that, but actually there's a risk, that's why there are ratios in place, to make sure you can give assurance about the quality of care provided, but I wouldn't want to invent an answer for you counsel.

Q. No, I'm not asking you to either but we've heard evidence that once you stretch the ratios, inevitably the attention to detail, which is the hallmark of intensive care medicine, inevitably gets diminished and in doing so you're not providing the same level of care. It follows, doesn't it, that if the ratios are stretched in the way that this hospital had to do, people are not getting the same type of care that they got pre-pandemic?

A. Well, there's an obvious risk not just in the type of care with the nurse ratios but about the outcomes, there's an obvious risk of different outcomes, and that is partly, I'm afraid, what coping looks like when you're flexing up numbers and you have more people who are seriously unwell coming into your system.

Q. So if I understand your evidence correctly, you consider that people that needed intensive care got it, albeit with the acknowledgement it may not have been the same level as at a pre-pandemic time. Is that a fair summary, Mr Gething?

A. Yeah, I think that is because, you know, in some parts of system the nursing ratio, the ratios of staff weren't the same, and I think it's important to recognise that, actually, that that's how our system coped with the extra demand that came in.

Q. Can I ask you about one of the quotations given by a critical care doctor in Wales to the research that the Inquiry undertook.

Can we have on screen, please, INQ000499523_22.

Mr Gething, this cannot be and nor is it suggested on behalf of the Inquiry this is necessarily representative. I hope you will take that into account but here is a critical care doctor who told the researchers:

"We knew it wouldn't help because we had come to see what kind of people died of this disease despite escalated care. So we decided not to admit to critical care whereas had they had a different illness, they probably would have been more likely to benefit so we would have escalated. We didn't have

enough space to give people a go who had a very remote chance of getting better. If we had had more capacity, we might have been in a position to try."

Were you aware of anecdotal or conversations that were taking place that suggested some people didn't get a chance to get intensive care when otherwise they might have done?

A. No. And that's very upsetting to read because that's a direct impact on an individual but also on a staff team who are making those choices.

Q. Do you think there ought to be a mechanism in Wales where that kind of frontline, very visceral experience is relayed to Dr Goodall, Mr Atherton, and the minister, so that they do appreciate that whatever the data says there are the most heartbreaking decisions being made on the front line?

A. Well, some might come to the networks that do exist, so Dr Atherton talking to medical directors, I would expect medical directors to be aware of what's happening on the front line. You know, Dr Kloer was a respiratory physician so, you know, I know that he would have thought about this himself. That's the same position for other medical clinicians and their specialities. I did know that heartbreaking choices were being made because I knew that was inevitable and unavoidable but

not specifically, but even in this anecdotal piece of evidence, that there were choices being made directly about whether people were going to be admitted to critical care is different to whether people admitted to non-invasive ventilation, CPAP, which is a different choice based on clinical evidence, but this suggests something different.

Q. May I just look briefly at one of the measures you took to try and make sure there was capacity and it's the issue of field hospitals in Wales. I think you say in your statement that you were essentially responsible for ensuring there was the funding for the field hospitals and providing strategic oversight, your words. Can I ask you, what strategy or strategic oversight did you provide?

A. So this is part of the planning assumptions and so I would have talked to Dr Goodall about where we are, about the likely challenges we'll face, about reasonable worst-case scenarios and what we need to provide for, and the field hospital network is part of doing that and you will see that the network shifted over time with the capacity in it. To provide a field hospital you need a building to do it in and you need to have some staff to provide for it as well, and I think you have evidence in front of you about the different model we had in

Wales about step up, step down, and not suggesting we'd use field hospitals for extra intensive care which I think was the right call.

So I would then have to go and make a case to the Star Chamber for additional support and I think in my statement I set out there was some push back from the Star Chamber about the scope and scale that was required. So I think that shows that scrutiny is real. And then the network is created and then after the first wave we then have a different and a smaller network of field hospitals available based on our experience going through the first wave as we're going into the second one.

Q. Obviously you make the point that once they were built and funded, which was -- really you're responsible for getting the money in, if I can put it like that, the operational decisions about how they were used lay with the health boards; is that correct?

A. Yes.

Q. Can I ask you, did you check as to how the field hospitals were being used?

A. Yes, I took an interest. So I knew that in the first wave we'd only had, I think, two or three field hospitals being used. So then in the operational -- then in the discussion I had with Dr Goodall about

planning for what was coming next, taking account of the fact we'd had field hospital capacity created that wasn't used and then what would it look like, and that then shifted again as we go into the second wave and we then get vaccination available. So the mission of the field hospital building changed a bit, but in the second wave we did see more people going through the step down care in particular in field hospitals that we couldn't have done on the acute hospital sites that we had.

Q. Given that it was a different model in Wales for step down care, was any thought given to using them for non-Covid care or for the re-establishment, for example, of elective care, particularly in wave 2?

A. I think the problem with that is that, you know, elective care often still requires a theatre. And if you require a theatre I don't think a field hospital is the place to go. That's when you're really at: this is the only thing left to do before the whole system collapses.

So the point about rehabilitation and about recovery, that sort of side of step down care, they do make sense, because otherwise you can't do anything. Some of your outpatient appointments could be used there as well. So there are probably other parts of the system and how they can work, yes, but not, I think,

when it comes to restarting elective lists.

Q. Different topic and that of PPE, please.

You say in your statement that you were the lead minister responsible for PPE. Can I ask you this. Did you understand that FFP3 masks were more protective than the FRSM blue masks?

A. Yes, and I had to learn quite a lot about this really quickly because previous to being a minister I hadn't taken much of an interest in the difference between masks, but understanding the difference was quite important when it came to numbers and stock.

Q. And when you came to learn it, when was that?

A. I can't give you a date. I'd be making that up. But actually as we got -- we issued the pandemic stock that we had. So we had a pandemic reserve that was part of a UK arrangement. And actually we thought we had six months' supply. That's what the stock was supposed to be for and of course we went through that a great deal faster than six months. So the urgency of PPE was there throughout wave 1. And certainly by the end of March, early April, it was a growing concern because we could see that we were burning through our stocks in usage terms and then all the points about what is appropriate, and people were fearful.

So the recommendations on appropriate PPE to use,

there was always an element of mistrust and people were essentially bidding up for the next stage of PPE protection, so understanding the volumes of each item, how that related to the guidance and recommendation made about appropriate PPE, and where and how you get it, and for me -- and I've said this before -- in April this was a bigger issue for me than testing because our understanding of the utility of testing at the time was different and the capacity of testing at the time was different but if you run out of PPE, if you're frontline staff, then you're in real, real trouble.

Q. A number of things I want to ask you about that answer. Can I just ask you this, who was it or which institution was it that led you to believe that FFP3 was more protective than the surgical mask?

A. It was the conversations I had both with Chief Medical Officer office but also then, just in the conversations about supply, so understanding why we had different grades of mask on the supply. So that would be both with -- so, Simon Dean and Alan Brace, who were finance director and deputy chief exec of NHS Wales respectively, but actually those don't really reflect what they were doing. Alan Brace undertook lots of the work with me on the stocks that we had and what they were for and because he'd been in a health board before

directly he understood a great deal about the operation of the service, not just from the financial level but the value you got from it, and so I had to pretty rapidly learn the different grades of equipment that we had and what that meant for staff.

Q. I think you say in your statement that at a national level you did not run out PPE; is that correct?

A. That's correct, we had some very real challenges in distribution so --

Q. You say in your statement also there were initial localised challenges and I wanted to know what did that actually really mean, Mr Gething?

A. There were reports -- some of this came from trade unions as well as from some of the chairs and chief execs in health boards about not being able to get PPE to frontline staff. They had been concerned and worried about PPE reaching them. And I think I also saw a news report that suggested in one part of the system at one point people were wearing refuse liners because they couldn't get gowns.

Now, that's not comfortable at any point in time particularly when there's a pandemic running. And actually to then see on a national level we think we have stocks, it's then about why isn't that stock getting to people on the front line, and so those are

questions that I don't just ask Dr Goodall or Alan Brace, those are questions then about, well, I need to know this is happening. And, actually, it came to not so much about how the distribution worked, so part of the reason we used a joint -- the joint service depots that local authorities ran, was that you then had more localised depots of things as well, because of course we had to supply social care too.

So each of those areas where it appeared that stocks hadn't got to the front line was a concern for me because, again, you still get into inadequate PPE should not be what our staff are expected to deal with, even if we think we have national stocks available, but if you have run out nationally then that really is into the scenario where you know you've got to have all the staff you need because you can't protect them.

Q. All right, a number of things I'd like to ask you about that.

Can I just take a step back to the pre-pandemic stockpile. I think you've told the Inquiry in previous modules that PPE stockpile planning was incomplete and that the plan, as we know, was for a flu pandemic, and had you had a flu pandemic you would have found it difficult and, of course, extra so given that, in fact, it turned out to be a Coronavirus pandemic.

Dr Goodall told us last week that the supply set aside was inadequate for a Coronavirus. Would you agree with that?

A. Yes.

Q. Can I understand from your perspective, did that mean you didn't have the right PPE or didn't have enough of the right PPE or both?

A. I think it was a bit of both. So I think there's the -- I think I covered it in my statement where some of the eye protectors were just not fit for purpose and so some of them had to be destroyed, which is not at all comfortable, and that was from the pandemic stock.

And it's also about understanding the different grades of protective equipment you've got and how quickly you're running through them as well.

So I know there is a lot of focus on masks but at one point we were worried about gloves as well.

Q. Yes, I was -- exactly -- going to ask you about that, Mr Gething.

To help you and those that are following, can we have up on screen, please, INQ000214235_21.

This is a report from the Auditor General about the procuring and supplying of PPE that was done in April 2021 but it looked back to 2020. And I think the plan was for the stockpile and other supplies to last at

least 15 weeks; is that right?

A. Yeah, even at the time we thought it would do, and you can see here that it didn't.

Q. Yes, exactly. If we look at the gloves about which you were just speaking, you can see that the stock there was at the 1 March, and from the week of 9 March you had one and a half weeks, it only lasted one and a half weeks?

A. Yes.

Q. That's probably the worst example on that page, but one can see there, again, nothing like the 15-week supply that you thought you would need to get through the initial stages of the pandemic.

So, clearly, going into the pandemic there was an inadequacy in the stockpile, with which I think you agree?

A. Correct. Although actually, once we got on top of gloves, aprons were a bigger issue. But I spent lots of time worrying about this and it did take up a significant portion of my time as a minister in understanding where we were, where our supply lines were and, you know, our arrangements with other parts of the UK as well in purchasing this as well.

Q. I think in fact -- you said aprons but I think it was in fact gowns. Dr Goodall said that you were down to about two days' supply of gowns across Wales.

Putting aside the national position, where you had enough, were you able to monitor what stock was held by each health board?

A. Not personally, because the figures I had -- I looked at the run rate. I eventually had figures about overall stock supply, then at the run rate that they were being issued, and then actually it was for health boards and local authorities to make sure that stock was distributed locally. If I tried to manage that or create a unit to manage that individually, I think we'd have stopped the system from working, bluntly.

But understanding the run rate that we had, so that was -- so how much we were actually going through as opposed to what we thought we'd go through, how does that mean we need to procure, and are we getting enough as well. I think the Audit Wales has lumped together aprons and gowns as opposed to seeing them separately -- but understanding the types of items we needed.

And, you know, with testing and with PPE there were frankly an awful lot of shysters who were trying to make money out of inadequate equipment. The whole world wanted more and some people saw that as an unscrupulous business opportunity, including inadequate equipment.

So the systems we had weren't just about buy anything, it was about buy what we need of the stuff

that can actually be used. And in the early weeks and the very real anxiety, we eventually got to a point where we were able to do that, but also the publication of stock I think helped with people's confidence about where we were, and that we were being upfront about it as well.

Q. I didn't mean to interrupt you, Mr Gething, but it may be her Ladyship's procurement module will look those that sought to take advantage of the difficulties of which you spoke. But can I ask you about a difficulty that was brought to your attention.

Can we have up on screen INQ000299062_7.

It's an email sent to you, Mr Gething, from a consultant at a hospital on 24 March, so very early on in the pandemic, and the sender says:

"Complete chaos at our hospital.

"No protection for nurses -- very low [morale] as being asked to care for patients admitted to Orthopaedic wards by medics with respiratory symptoms.

"Masks not being released."

So a direct line in to you there of some very real problems in that particular hospital.

What did you do, personally, to follow up on this and ensure that the problems being spoken of in an email like that were in fact being resolved?

A. Well, I think the email trail that you have shows that I didn't just pass the message on and say "Please deal with this", it was a conversation that I then had with our officials, with Dr Goodall and others, about "Where are we? What's happening?"

And actually, as a minister, when you poke and prod and say "I want to know this", it does almost always deliver a response. So the work that we then had to do on -- because often you just assume that PPE is veil. As a minister you don't normally say "I want to see all of this personally". Then, understanding there is an issue both with how the system's being run, how staff feel, but with PPE as part of it, as a specific part of that -- and I got not just interested but I did something about it, as the email trail I think shows in the rest of the document, and it did lead to a greater structure being put in place where I then had regular updates about PPE stock, how it was done, and it led to me making choices about publication. Not just this individual but this was an issue that was raised consistently by trade unions in the first couple of months as well.

Q. Yes. Can you help, how often did you get an email like this, Mr Gething, across your time as minister?

A. Rarely.

Q. Okay.

A. So, as I say, the system is small compared to England, so there are people, when you go around and visit, you meet them two or three times, so eventually they feel they can trust you and tell you things. But in the pandemic I did not get a -- regular point-of-contact emails from consultants, including those that I'd met, saying "This is the problem I have in my workplace, can you do something about it?" It's part of the reason that I took it seriously, was this was an unusual intervention from an area of the country that we expected there to be real concern, because of the socioeconomic grading we expected (unclear).

Q. You mentioned there I think the TUC bringing issues to your attention. I think one of the things they say in their statement to the Inquiry was that some workers had to resort to wearing bin bags or buying visors, goggles and hairbands on which to hook poorly-fitted face masks. In some places, home-made PPE was donated to workers, the use of which was available sometimes increased their risk of infection and in some cases led to workers being reprimanded.

Mr Gething, we also heard from Jonathan Rees, a pharmacist, who, amongst other things, told us that a local school's DT department started making masks and

their own hand gel to provide it to the pharmacists.

Were reports like that being brought to your attention throughout waves 1 and 2?

A. Yes, so in wave 1, not in wave 2.

Q. Right.

A. So in wave 1 I'd seen a news report of bin bags being used, which really did concern me. And the email you've just brought up is from the start of -- well, the start of lockdown, March 24th. We'd just gone into lockdown. And -- so, yes, that was part of the reason I took an extra interest.

When we got into wave 2 actually, our procurement and delivery systems I didn't get anything like the same concern at all, and we'd had regularised use of other parts of our system that were making products. So hand sanitiser is probably the easiest example, because lots of people made it, lots of breweries and distilleries ended up making lots of hand gel. You know, I've still got -- still got hand gel items around the house from all the people that made enormous amounts of it. And the making of the visors as well.

So lots of that happened and we had a call-out to the private sector to help us with it. We also had the materials of (unclear) that looked at items to make sure they could be quality assured. So in wave 1 it was

a real concern, particularly in the first half of wave 1. Then we had regularised and managed to get enough supply in, including mutual aid from other parts of the UK, that we both received and contributed to. And then I think it was on a more even keel. But it was one of those things where people were always concerned: have I got the right PPE, and will I have access to it when I need it?

And that's why the publication of the stock levels -- that came from a conversation with trade unions. So the RCN, UNISON, Unite, the GMB and the smaller unions, including the ones representing therapists. Those conversations mattered because it did lead to the assurance that I think made a difference.

Q. Given the concerns that were raised to you, whether it be by email, in conversations with TUC, with other stakeholders, do you accept that at times in wave 1 it appears that healthcare workers in Wales treated Covid-19 patients with inadequate PPE at potential risk to their own health?

A. I'm afraid that's possible, yes.

Q. Finally on PPE, were you aware of issues that FFP3 masks did not always fit women or did not fit people from a non-white ethnicity?

A. Yes. So the problem about fit tests was real, and that

definitely did get raised. And it was part of the point about what was being procured and actually about making sure the fit test process was done properly. So people have different size and shape heads, and so were these masks essentially made for big blokes and not for women? What about men with beards as well?

So there were real issues about fit tests for a number of workers. Because, you know, healthcare workers don't come in one simple shape or size. So the fit test process mattered.

That also made a difference about wanting to make sure that we procured items that people could safely use.

Q. And what did you actually do then to ensure there was a sufficient variety of FFP3 masks to fit the BAME workers, to fit women, to fit people who had beards? What did you do, Minister?

A. So that came up in the conversations that I had with officials, not just about the stock but, as it became more of an issue, about, "Look, there's an issue about how these masks fit everyone". So again, with the group officials that I worked with and I had responsibility for, we did go through not just the concerns that were being raised but about what was being done. So, you know, that assurance process did take place in direct

conversations with the team and the work that shared services were doing on procurement as well. So it wasn't a simple "shrug your shoulders, never mind", it was: well, what are we doing about it? And that's assurance I got from officials.

Q. By the time you left your position, were you satisfied that there was a sufficient variety of types of FFP3 masks to fit a broader range of face sizes, shapes, ethnicities and the like?

A. That was my understand, certainly. And actually, in the heat of the second wave, again, I don't recall there being conversations with me about the fact that there was a regular shortage or a shortage of the right type of mask. But I know that it was a regular point about having fit tests done, particularly when you had a new group of staff who needed to be redeployed into areas, as well.

Q. Can I leave PPE for a moment and ask about some other topics perhaps before we take our mid-morning break.

Can I ask you, please, about Long Covid. It was known at the start of the pandemic that it was likely there would be long-term effects caused by the virus. Was that brought to your attention? Even if they don't know the specific types of long-term consequences.

A. Yes. So at the start understanding that for most people

it would be a mild and transient condition but for a significant number of people, even if a small proportion, it would be much more serious and the recovery was uncertain for some of them. Yes, and the challenge is always then about learning as you're going -- and not understanding what it was going to look like at the outset.

Q. Can you remember when it was you became made aware that there was likely to be some long-term consequences? Perhaps even -- not necessarily before it was named "Long Covid" but at least the acknowledgement that there would be a long-term --

A. I can't remember the exact date but I do recall having conversations with the chief therapist and the conversation with her about rehab. So part of this was about the wider system, how it was also about how you help people with rehabilitation from Covid. So it wasn't called Long Covid at the time, but if you obviously know it's something that affects your organs and actually how do you help people, that's -- that's definitely in the rehab space. So I had a conversation with the chief therapist adviser and she was one of the lead people on looking at what we should do to support people with what has become known commonly as Long Covid, with the long-term consequences.

Q. In your statement you say that in May 2020 you agreed a national framework for rehabilitation. Does it follow from what you've just said that your conversation with, for example, the chief therapist happened before that framework was brought into being?
A. Yes. Yes. So I definitely had a conversation with her about the work that was being done to deliver a framework before the framework was published. It isn't the way that you learn about those things on the day.
Q. Now, in Wales, the approach was to support the rehabilitation of those who had had Covid-19 but were still suffering from its aftereffects. It was decided that that should be delivered at local level through existing primary and community care services. Why was that decision taken in Wales?
A. Because that seemed the most sensible way to do so, given the way our system is organised and run, given the way that A Healthier Wales talks about how we want to run the system. So services that need to be highly specialist, where people need to travel for care taking place, and other services being delivered as locally as possible. And actually I think this really is a space that should be primary care led rather than requiring people to travel to secondary care facilities, and it's

then about making sure we have the staff to do it and the knowledge and understanding to do it as well.
Q. How did you ensure yourself that that level of care was being provided through primary and community care services?
A. So we have the framework we provide. It's then about our understanding of what is taking place. And so, you know, health boards have the responsibility to deliver on the strategic choices that are made, and I was aware that there were -- as we went through the pandemic there were ongoing conversations about Long Covid and its treatment and also about getting staff equipped to understand what Long Covid was, because it was a new condition for them to see as well. And I know that caused some distress for people suffering with Long Covid, but actually how you get this as a regular part of care that is delivered as locally as possible. And I expect it to be a standard part of the way primary care still work today because there are people with the condition today who will almost certainly get almost all of their care needs delivered in primary care.
Q. That May framework I think was updated in October, and can I ask that we have a look at your paragraph 345, Mr Gething, in your statement.
It's INQ000474252_130.

It may be coming up on screen for you as well, Mr Gething. There you are.
A. Yes.
Q. Paragraph 345, you provided the update in October 2020.
"At that time the longer term impacts of Covid-19 were becoming clearer. In Wales we did not have plans to develop rehabilitation centres as in England. It was anticipated that it would be a relatively small number overall of people recovering from Covid-19. Instead, our approach was focused on providing care and support as close to home as possible ..."
Can I ask you about the line that says it was anticipated there would be a relatively small number overall of people recovering. On what was that based?
A. I can't recall who gave the advice but that would have been the advice on the numbers of people who were having longer-term consequences, people who are still having challenge from Covid after 4 and 12 weeks.
The thing about the number of people that had Covid -- I have had Covid twice -- and it's a proportion as opposed to an overall number, and it is then about how you deliver the services people require. We had two national centres in Wales. It would have been convenient for a small number of the population and everyone else would have been inconvenienced.

And equally, if it isn't part of primary care, then essentially you're managing up from primary care into two specialist centres, and I don't think that approach would have worked in Wales and would have been wholly contrary to the method that we'd set out in A Healthier Wales itself.
Q. I understand that, Mr Gething. It's not about how you decided then to divide it up geographically but what was the relatively small number upon which you were basing the decision about how to treat and care for people with Long Covid? 1,000, 10%, what was the figure in mind?
A. I can't recall without looking at the statement and going back into the documents, and there's almost certainly ministerial advice around this as well.
Q. All right. It's just that Long Covid data certainly wasn't being collected by the ONS until April 2021. And as at that stage, 56,000 people in Wales were being -- have certainly self-reported as suffering from Long Covid. Was that the relatively small number that was being envisaged in this paragraph?
A. I couldn't tell you because, without going through the documents, I'd be inventing an answer and I'm very keen not to do that.
Q. All right.
A. From October 2020 till now I think it's fair to say that

we have -- because we hadn't been through the second wave in particular as well, we have a larger number of people. It's a much more common condition of significant variants that we'd have anticipated in autumn 2020.

Q. All right. Well, let me ask you this. There may be some, in this room even, that think that because you thought it was going to be a small number that's why Long Covid clinics were not set up in Wales. Is that a fair comment to make or not from your perspective?

A. No. And I think if you look at the advice that I received at the time and acted on, the statements I gave, it was actually what's the appropriate model of care to make sure that care is local, to make sure that care is easily accessible. And you help them do what they can do with and for themselves with support, and where they need intervention or support from a healthcare worker that's available as well. So it's really about what you think the right model is rather than wanting to underplay the importance of it.

Q. All right. You've set out the rationale for the different approach in Wales. But evidence received by the Inquiry suggests that the Welsh approach means that patients who are referred by primary care to specialised services now end up having to go and see a number of

specialists rather than if you had a Long Covid clinic model it would be a more of a one-stop shop.

Did you appreciate that, in setting it up in this way, there may be a need for those who have very many Long Covid symptoms to now have to go and speak to very many specialists?

A. Well, there's always the -- about how you learn from the different models that are available, and I know that Judith Paget has given observance on this as well. I'm always interested in how we learn from the way we got different delivery models and what that means in terms of outcomes in patient experience.

I don't want to get drawn into trying to adjudicate on the right clinical model, because whoever the health secretary is in Wales will have to look at that clinical evidence and listen to patient experience, and I think you have evidence before you in the Inquiry about the engagement did take place between medical officers and the chief therapist adviser and patient representatives living with Long Covid as well.

Q. Can you help how, when you were minister, were you provided with information about the numbers of people with Long Covid, if all?

A. So it was both in the conversations that I had about the rehab framework, the focus on Long Covid, the statement

that I gave on Long Covid in the October. And I think there was a further conversation that took place in the spring as we were going through. So spring 2021.

So it was the engagement with -- and, from my perspective, the lead person that I spoke to was the chief therapist adviser, because lots of support people required was in the therapy space, but of course -- and there was for some people a medical need as well. That's the challenge you're dealing with. It's not one condition, because it affects people differently, so that's why you need to have a framework that takes account of different need.

Q. Do you know whether there was any central reporting of the number of healthcare workers that were diagnosed with Long Covid?

A. It's my understanding that we didn't have that. And so you have this challenge of wanting to understand what happens on a whole system but you've then got to marry up someone's employment record with their individual patient record. You need people's permission to do that. I think it would be really helpful to understand the number of healthcare workers affected but that does mean you've got to get permission from those people to gain access to that information on an onward basis.

Q. Do you think that data should be collected by the health

boards and then fed up to government or it should be collated nationally?

A. Well, the starting challenge is you've got to agree a consistent way of asking healthcare workers if they've had Long Covid and then whether you want them to self-report or whether you want to access their medical records to understand the interventions given.

Employers, where there is an impact on that person's ability to work, should understand that, and so there may be an opportunity to do something on an anonymised basis, but I still think you'd need to agree that in partnership with the trade union side, because there's always the risk that people fear that if you're looking at how my employment has been affected by a healthcare condition that it's not always for a benign or a positive purpose. I say that thinking back to my own time when I had a real job as a lawyer.

Q. I remember it well.

Let me ask you this though. It's not so much about the difficulties in who is going to provide permission or not but who do you say should be the body responsible for collecting the data. Putting all the difficulties with collecting it aside, who is going to do this, Mr Gething?

A. Well, I think really health boards and trusts and

employers are the ones that are best placed to collate the data but that would almost certainly come from a national agreement or the Welsh Government on what to do broadly about collecting data but also why. So you're not just collecting data for the sake of it but why and what do we want to understand, how does that help us understand the scale of the problem, understand what to do about it, understand practical approaches to supporting people with Long Covid, and to keep them in the workforce, which I think would be largely the objective. So I think there would be value in doing that, but you need to ask yourself some of those questions first otherwise you'll end up with potentially seven different approaches.

MS CAREY: Mr Gething, that maybe takes us conveniently to our mid-morning break.

LADY HALLETT: It is. I shall return at 11.30.

MS CAREY: Thank you, my Lady.

(11.14 am)

(A short break)

(11.30 am)

LADY HALLETT: Ms Carey.

MS CAREY: Thank you, my Lady.

Mr Gething, can you hear me all right?

A. I can hear you fine, thank you.

Q. Can I turn to nosocomial infections and the testing of the healthcare workers, and can I ask you this. At your paragraph 295 you set out that at the start of the pandemic, on 21 March of 2020, Wales set an ambition of 6,000 tests a day by 1 April, 8,000 a week later, by 7 April, and 9,000 by the end of April.

Can I ask you, was that a target ambition to cover tests for patients and healthcare workers?

A. Yeah, it was to use the tests in accordance with what we thought the value of testing was at that point in time. So symptomatic patients and workers, yes.

Q. Were any of those targets met?

A. No. And I think I explain it in the following paragraph about the unfortunate business with Roche and the way they engaged with us, Wales and England.

Q. Yes, you do. It's set out at your paragraph 296, Mr Gething.

But I think in fact by mid-April, 20 April, the 9,000 testing target for the end of that month was abandoned as well.

Do you know how far short Wales had fallen as at 1 April, 7 April and the end of April?

A. Well, apart from the 5,000 that we thought we'd get, I think we also had some issues with supply chain, because -- I'm not sure if this is in my statement or in

others, but equipment that had been pre-ordered by Public Health Wales hadn't always arrived and we also had issues with some of the reagents as well. So I think -- without the 5,000, I think we were far short, but I haven't got that in front of me.

Q. All right. So you don't know what the position was at 1 April, whether you had 1,000, 1,500, 2,000, what you had by 7 April or what you had by the end of April?

A. I can't tell you offhand but there will be figures available about the amount of testing that we had and how it was deployed.

Q. All right.

I ask about testing because clearly it has an impact or an effect on nosocomial transmission and how one tries to prevent acquiring hospital-acquired infection. In Wales, is this right, that the Nosocomial Transmission Group was established on 19 May of 2020, and you say in your statement that that was a group that did not report to ministers.

Why did that group not report to ministers?

A. The group didn't formally report to ministers in the chain, as it were, because the chairs and co-chairs that -- the Deputy Chief Medical Officer and the chief nurse were part of a senior group of officials, and so actually our understanding of what was happening at the

time -- I had reports both from the Chief Scientific Adviser for Health, the TUC and TAG group, the chief medical adviser and the chief exec directly to me. So nosocomial transmission was a real concern that was readily discussed with me and it was one of the Chief Medical Officer's concerns about the estate that we had and about the fact that it didn't make for good infection prevention and control.

Q. There was evidence, I think, of nosocomial transmission certainly in one of the health boards from as far back as March 2020.

Can you help with why it was that the group wasn't set up then until 19 May 2020?

A. So, nosocomial transmission is a regular feature of healthcare work and the fact that people can get additional conditions whilst they're undertaking healthcare for something different. And so, given we knew it was an infectious disease -- an infectious condition, I understood there would be some nosocomial infection.

And the evidence about what was taking place in March wasn't really revealed until later. I think there's a document in evidence about a study that showed that there was a cluster in Aneurin Bevan that (inaudible) driven by nosocomial transmission. But the

challenge is how you get people to adhere to good IPC practice, how you have PPE to help with that and how the estate helps or hinders with that as well.

Q. I understand that. In fact it was Public Health Wales that produced a report on 31 March which certainly showed there were outbreaks in Aneurin Bevan, I think, that was consistent with nosocomial transmission.

It's not the fact that everyone acknowledges there may be nosocomial transmission, the question is why it took so long to set up the group, given that it is obvious to all there will be at least some healthcare-acquired infection?

A. Because this is part of how a health service operates, and there should be a focus on good IPC practice as a regular part of healthcare.

So pre-pandemic it was one of the things that I spoke to chairs and others about, about the levels of healthcare-acquired infection that took place. And so there is something about -- it's about practice, it's about how rigorous that is. And, you know, not just, if you're the minister, going on a visit about making sure you roll your sleeves and tuck your tie in but actually what happens as a matter of course. So you don't see, you know, old pictures of, you know, consultants with long sleeves and a tie wound around leaning over people.

Actually, it's the (*inaudible-cough*) that things matter.

The group was there to give a focus to what was happening, to try to draw together what was taking place nationally. So it was a response to what was taking place in front of us.

Q. All right. I suppose the question is, really, do you think that response was too slow? Given that you knew at the end of the March that it was happening, that it inevitably always happens, why not set up the group sooner?

A. Because the expectation is that this is what happens normally and you should have -- as in normally you should have people getting on top of nosocomial transmission. And when you see it isn't, it's then what you do about it. There's the normal line management, whether that's the CMO or DCMO talking to medical directors, the chief nurse talking to nurse directors, and then actually, as that didn't -- didn't deliver, this group was set up.

I think it's fair to ask the question about how soon is it set up in a future pandemic, how soon do you actually reiterate the need for fairly rigorous adherence to good IPC practice and the fact that there are consequences for healthcare workers and patients if you don't.

So, look, I'm perfectly prepared to accept that -- even in the moment and at the time, could we have acted earlier? Quite possibly. For the future, it is one of the things that I think is worth doing, about saying: make sure if we have an infectious disease in a pandemic that nosocomial transmission is an early priority, with a rigorous reinforcement of why good IPC practice is essential.

Q. All right. Can we have a look at some of the figures, please.

Can I ask that be put on screen INQ000396261.

This is, in fact, a briefing I think provided by the Nosocomial Transmission Group on 15 November of 2020, and it sets out not just hospitals but care homes but I'm obviously just going to focus for today's purposes on hospitals.

As at November 2020, rates there are increasing as community transmission has increased. We can see there during the last week until 8 November there were 210 cases of probable or definite acquired Covid, which represents 3% of all cases diagnosed but 50% of all cases diagnosed in hospitals.

And then set out per board the number of cases and the percentages. We can see there Cwm Taf with the highest number, followed by Swansea Bay.

And indeed, if one goes down the page a little bit, reference to the Public Health Wales data indicating how many patients were Covid positive in hospitals, how many beds were occupied by people who didn't have Covid:

"... around 3.5% are being infected each week by COVID-19 within the hospital environment."

That's presumably across the whole of Wales.

And I think it's this:

"The evidence suggests that properly used [PPE] limits transmission between staff and patients but that transmission is occurring between ...

"Transmission between staff is often seen as a result of a lack of social distancing in non-clinical areas. Although staff should test positive at a similar rate to their local community, one Health Board ... found 24% of staff were positive despite an approximately 1% community prevalence."

When you received this briefing, what steps, if any, did you take to try to ensure that IPC measures were being properly enforced, that there was properly used PPE, that you were limiting, insofar as you were able, Mr Gething, to ensure there was social distancing in non-clinical areas?

A. So I can't recall definitively what I did in response to

this particular briefing but I do recall that about this time is when we were going to further iterations of what we would do in the testing, testing around outbreaks, whether at care homes or hospitals, and we knew that we had outbreaks around hospitals where we had undertaken wider testing, and the testing infrastructure was becoming more -- more portable, because this is just on the cusp of lateral flow devices. So I think we'd used lateral flow devices around potential outbreaks as well. So this was around, again, the reiteration of why it's important.

And I think the transition between staff and the lack of social distancing in non-clinical areas, that's really difficult because -- and I wouldn't want this to be seen as a staff not being interested about this but actually it's the pressure they're under and it's what happens when they feel a sense of relief at not being in a clinical area. It's a fairly human response. But there are consequences -- and that's why the rigour in not doing this really matters.

So I recall having conversations with the DCMO and the chief nurse about nosocomial transmissions, had reports they were bringing back from this group and what they were looking to do to try to make sure that our whole system responded.

I can't recall for you whether I had a conversation directly with this about chairs but I know that chairs of health boards raised it themselves about things that they were concerned about throughout the pandemic.

Q. May I ask you this. A number of times this morning you've spoken about the conversations you were having, and you've told us about how it's a smaller community in Wales and so perhaps doesn't have the formality that one might otherwise expect, but how are these conversations recorded so people know what it is you've told them that you want done?

A. So if I'm having a meeting with the chief nurse, there will be a brief minute. There'll be a minute of the meeting. It won't capture chapter and verse about what's being done. There are minutes taken of meetings with chairs of health boards. There are -- the conversations with trade unions are more about us agreeing action points at the end of that rather than there being an exhaustive minute of it. So, you know, in the -- in the significant number of documents there should be documents that point out when those conversations are taking place, not just the briefings delivered but also should -- you've got to see practice from those service leaders about what they're asking the

service to do.

And the fact that this data wasn't kept secret in that sense, health boards knew they had problems, and in fact the way Test, Trace, Protect was deploying testing resources about outbreaks, again every time was reiterating: there is a reason why this is happening, protect yourself and the people you care for when it comes to the service.

But this is very, very uncomfortable, in the pandemic and now, about understanding that infections on a hospital estate were a real factor in the harm that was caused.

Q. I think you have seen that there was a second briefing by the Nosocomial Transmission Group in February 2021 which showed a position that had worsened from the November 2020, with effectively higher rates of nosocomial infection.

Did you put into place any steps between wave 1 and wave 2 to try to reduce the amount of nosocomial transmission, and if so what were they?

A. I can't give you a documentary review now without pointing to a particular document. But I am clear that the Nosocomial Transmission Group directly impacted on conversations with chief execs and chairs about what was happening. And I'm pretty sure it was part of the

operating framework, as well, about how people were supposed to be dealing with where we were. And it's not a surprise to me that transmission increased by the time we got to February because we then had a more transmissible variant in circulation across the great majority of Wales. So even if there had been an improvement in practice, actually, Covid was even better at spreading.

Q. Yes, everyone understands that that variant was more transmissible. But that might be seen by some to be an easy excuse to explain away what, on one view, is a worsening position from what was already bad in November 2020, to incredibly bad by February 2021. Was there anything done to try and establish whether it was the sheer transmissibility, or whether IPC had improved, or worsened? Do you see the point I'm making?

A. Yeah, and so my understanding is that the Nosocomial Transmission Group and its direct engagement with the service and the leadership around that is what should have made the difference. And, in particular, nurse directors have a lead role on IPC and their health boards, around the practice and the culture developed around it. The challenge is when you recognise something has gone wrong, how you then get back to it, and I know it is, again, one of the points, I think, of

learning for the future about the importance of IPC because there's no sugar coating the fact that the position worsened and real harm was caused. So I'm not trying to avoid that; it's an explanation rather than an excuse.

Q. A slightly different topic but related. Did you consider or receive any information about the impact of nosocomial transmission on patients who were clinically more vulnerable given that those who are clinically vulnerable are more likely to need to go into healthcare settings to receive their ongoing treatment? Was that brought to your attention at all, Mr Gething?

A. I don't think I had a specific report about nosocomial transmission and the clinically vulnerable but I always understood that people with greater comorbidities that we saw in our hospital estate in the second wave in particular and in even larger numbers and the fact that hospitals were fuller at the start of it because we'd restarted some activity, meant that there was a greater potential for harm.

Q. In March 2021 there was a framework for Covid testing of patients in hospitals in Wales. Do you think that that framework was published too late, given the rates of nosocomial infection that we've just looked at?

A. Well, by that point we'd been testing patients on entry

into hospitals and during their time in hospital as well. The framework draws together both the updated evidence but also practice that has already been taking place, and that was important both for entry as well as treatment as well as discharge. Discharge had been a real issue throughout the pandemic, and having the confidence of people who no longer had Covid or were no longer infectious before they could be moved.

So the framework in March drew together practice that had already been taking place as opposed to an entirely novel approach where no testing had been taking place before then.

Q. You've mentioned a number of times the hospital estate in Wales. Were -- did you receive any requests for funding to increase ventilation, particularly for example HEPA filters or other portable ventilation, to try and assist with that aspect of IPC?

A. I can't recall if I did or if I cleared ministerial advices on that basis but I do know that health boards did manage to install additional ventilation. Again, I know that in Phil Kloer's evidence he points out that in Glangwili you couldn't open windows all the way open -- and there's a good reason for that, but they did manage to acquire additional mechanical ventilation to help with that.

Q. Given that you lived through it as minister, do you consider there is a need for more steps to improve ventilation within the NHS Wales estate as a mitigation against future pandemics?

A. Yes, but the starting point is what does the estate look like now and what will it look like in the future, because, actually, it would be a better answer to have a new premises as the main DGH for West Wales rather than retrofitting on to old buildings. But if you can't deliver that entirely new estate then of course you need to take the steps and the measures that you can do.

Q. All right. DGH, district general hospital, is that what you meant?

A. District general hospital.

Q. Finally this, please, on nosocomial. Were there any investigations set up in your time to investigate cluster outbreaks in hospitals?

A. Yes, so I recall, for example, an outbreak in Wrexham where there was an investigation about why it had happened and how, as well as the testing for a wider group of staff as well. So -- and that approach was being taken where outbreaks took place, but the Wrexham example is one that sticks in my mind.

Q. May I, in the few minutes I have with you, Mr Gething, go through a number of discrete topics. The fact that

I am dealing with it quickly should not be taken to diminish its importance. It's just there may be other questions that are asked about it around the room.

Can I start with shielding. In Wales, we know that, obviously, shielding was brought in in March 2020 until at least 15 June but, in fact, you did not pause it, I think, on 31 July as other countries did, but extended it to 16 August 2020; is that correct?

A. Well, actually, we maintained at the time we'd already announced. If we'd ended it on 31 July we would have had to bring the end of shielding forward. We had already told people we'd shield to that point in August and I've set that out in my evidence.

Q. I think you said you didn't pause it earlier but extended it to 16 August to give, in part, people time to prepare as a result of concerns raised by the Disability Equality Forum and because you were concerned that people felt, to use your words, abandoned not liberated.

A. People were fearful and if we told them everything is fine, go out and about but be careful, I think we'd have had a real challenge if we'd have said we're ending shielding early, because that would have been the message. And, again, looking in hindsight, I think how you manage an intervention like shielding, how you tell

people "You are particularly vulnerable so take extra care", and then how you bring people out of shielding is actually really difficult in terms of managing human behaviour. Because, you know, at that point I thought the summer was going to be as good as it was going to get for a while. I didn't quite anticipate the speed of the second wave in the autumn into the winter. But again, it's one of those decisions where there is harm whichever way you look at it, as well as potential benefit.

Q. How were the concerns about feeling abandoned, liberated, people being worried about how disability groups would be able to manage the transition, how were they raised with you, Mr Gething, through what fora?

A. So there was a direct conversation with Jane Hutt who was a deputy minister dealing with the sector at the time, I think the Chief Medical Officer attended as well. I even had those conversations, direct reports back around how people felt, and so I had looked at what the feedback we were getting and how you help people to feel that they're being supported, that's both with the volunteers who were in place by then. But the food boxes weren't just, I think, eventually about having a supply, but it's also contact with other people.

And I had to go and see my own mother. And so

actually me delivering her shopping meant she saw someone and, you know, regularly having to tell her "I can't come in and I can't give you a hug" was difficult, but I actually got to talk to her. So part of that was about the contact people had and the connection and at the same time not wanting to feel that people are going to be made vulnerable if they have too much contact with other people. If my mother had got Covid, it would almost certainly have been from me, because for a substantial period of time, as well as my duties, I was the only person who was going to visit.

Q. May I ask you about data and, in particular, can I ask you about ethnicity data in Wales.

I think you know from the work of the subgroup of the BAME Covid-19 advisory group that there was a disproportionate impact on minority ethnic communities.

Could we have up on screen, please, INQ000227599_2.

It's the front page, Mr Gething, of a report from the BAME Covid-19 Socioeconomic Subgroup from June 2020.

And if we could just look at the "Racial Inequalities" section:

"The report finds that race inequalities exist in Wales. In light of Covid-19, the lack of or poor

quality of ethnicity data has resulted in poor health decisions, and BAME communities face a higher risk of catching and dying from the disease. Also captured are the experiences of racism from specific BAME groups exacerbated by Covid-19 ..."

Did you -- do you agree that going into the pandemic there was a lack of or poor quality of ethnicity data?

A. Yes. So the data fields weren't always completed or pursued. We understood generally what our health service workforce looked like with a higher degree of black and brown people within it than the wider population, and actually people within our communities. None of what this part of the report says was a surprise to me at all.

Q. With that in mind, why was the data, though -- if it's not surprising, why was the data so poor, why haven't you and other ministers done something to improve the quality of the data?

A. Well, the quality of the data requires you to invest in it and it requires there to be a response, we had staff alongside understanding why the data matters and what it's going to do. So we set out a series of responses, I think I have covered these in some detail in my statement, about what we were doing to try to improve

the data, and it's also why the risk tool was developed, reflective of the fact that ethnicity was a factor in the level of your risk as well. Trying to capture those different fields of data, isn't just about a celebration of diversity in the service, it's practical as well, and that's why in responses we finally had some -- a practical shift behind -- there's a real practical reason to do this in amongst all the other priorities that the service has to deliver.

Q. Can I go on in this document to page 8, please, because the recommendation of the subgroup was this. To:

"Take immediate action to improve the quality of recording of ethnicity data in the NHS and across health and social care services to ensure parity of BAME data collection, monitoring and reporting."

What immediate action did you take as minister, Mr Gething?

A. So this was part of the response I set out in my statement in 164, paragraph 164, I go through it in some detail about not just what was happening in the NHS but across the government. So there is more data that's been collected. There are still gaps and there are further steps that are being taken to understand how we improve that data on the workforce.

So it's not as simple as you flick a switch and

then two weeks later all the data exists. And frankly, if we had tried to do that in the middle of the pandemic I think we would have got a pretty robust response.

But it is about understanding and improving the data we have for a purpose. And like I said, that purpose is not just borne out in this but it's about who you recruit, who you retain, where they are in the service. Some of that I'm aware of from before my time in public life as well as the reality of where we still are now.

So we're in a better place than we were at the time the report was published but there's a good deal further to go.

Q. Do you feel the paucity or lack of the data available to you for ethnicity affected any of the decisions that you took whilst you were minister or had there been better data you might have taken a different decision?

A. I think once the data became aware that different ethnic groups had a higher risk to harm from Covid, if we knew that earlier then we might have made other choices. When we had the risk tool, it was helpful. It provoked individual conversations about what took place. So some of this was about ethnicity data. But some of it also was about occupational segregation as well. So the fact that being a taxi driver or a bus driver meant you had

a higher likelihood of getting Covid than being a teacher was evident from the data, but also some of that also overlaid with the ethnicity data as well.

So it's about the wider population in addition to what we're doing in the service. But I couldn't point to an individual example that if we had had better data in February 2020 we'd have made different choices because actually the learning on the differential impact for ethnic groups came during the first wave not before it.

Q. In relation to different data, was any department or organisation that you are aware of monitoring the deaths of healthcare workers from Covid in Wales?

A. I saw figures on deaths of healthcare workers at various points in time. So employing organisations were aware, of course, and they reported those deaths. And I can't remember if it was Public Health Wales or if it was through health boards and trusts themselves. But, yes, I was aware that healthcare workers lost their lives and I was aware of the impact that had.

I know sometimes large organisations can seem remote, but in my dealings with chairs I can tell you they really were affected when members of staff lost their lives.

Q. A different effect on healthcare workers. You've told

us about how the views of the frontline via your conversations with the BMA, the royal colleges, alike, were helpful to you. I think you are aware there was a nursing survey done in November 2020 where 34% of staff felt undervalued by the Welsh Government which was the highest percentage across the UK, and that 74% had seen increase in stress levels. When you were made aware of the feelings of undervalue by the nurses, what steps did you take to try and mitigate or make less bad, I should say, the undervaluing that they were feeling?

A. So I discussed the report with the chief nurse. I'd been caught off-guard by the report because for all of the regular conversations we had, I learnt about this survey when the press release came out. And so actually then, understanding what you do to try to understand why people feel less valued from the headline figure was actually, you know, I placed enormous store on what our staff were doing.

So from my own position, I'd always valued our staff because you can't run the service without them and I valued that because of my own interaction as a patient.

So it's how you get over and understand that people feel bruised and not recognised. Sometimes that's through pay and reward. A lot of the time it's

through what you say as well. But I know that the chief nurse had conversations with all the nursing directors and it came up again when I had those conversations with the trade union groups as well.

Q. Three short topics I must cover.

DNACPRs, Mr Gething. At any stage of the pandemic whilst you were minister, were you made aware of concerns about blanket or inappropriate DNACPRs being imposed and, if so, what did you do in response to those concerns being raised?

A. Yes, so the Older People's Commissioner raised general concerns about DNACPRs. She didn't give me any specific examples but we did have certainly an instance where a practice had written to people, I think suggesting DNACPRs and that just wasn't appropriate or in line with policy. So we dealt with that not just with the practice and the board but we did then re-issue the guidance and make clear the guidance that had come through the Ethical Advisory Group, and I think the CMO and the CNO wrote out to health boards, medical directors and nurses, but part of the challenge is in how you get over to people the pandemic doesn't change DNACPRs, there should be an individual conversation about that with the person, with their family about what this means, and it was never appropriate to have

a blanket policy and I know some disability groups were concerned as well.

So I think we re-issued and reiterated the guidance on several occasions and I certainly publicly dealt with the issue with the general practice that was brought to my attention.

Q. Visiting restrictions, please. In your statement you set out that you were very sympathetic to those affected by visiting restrictions, particularly within the maternity setting.

Looking back now, Mr Gething, do you consider that the visiting restrictions struck the right balance between the benefits of visits to patients and their families and reducing the risk of visits bringing in infection?

A. In hindsight I think that we might have done more to enable visits. In the maternity field having whoever your birth partner is, whether it's the other half of a woman giving birth, or not, I think the support for the women giving birth but also -- and I think about this because there was such -- I think about my own life and becoming a parent and if I had been a new parent in the pandemic and not able to go to the scans, you can't get that back, and so there's the challenge of how you then have enough safeguarding place to make sure that

you're doing all those things in a way that matters and, in particular, people with cognitive impairments, and visiting is a part how to keep that person well. So our ability to scale up testing to make that safe but to appreciate the harm being done if people can't go there and to balance that with the very real fear that staff had about additional transmission.

So there is always a balance to be struck but I think the chief nurse at the time has reflected on this and I think it's definitely a learning point for the future about how you strike that balance and how you explain it and then how you review the evidence over the different harms that are being done in practice.

Q. You said there "with hindsight we could have done more". Can you think of a practical suggestion of what more could be done absent testing being available?

A. Well, we could have used PPE as control measures but you're still dealing with risk and it's the balance of risk as opposed to saying there was no risk. Having -- in particular, if a couple live together and one part of that couple goes in for the scan, there's a fair argument about whether actually you're reducing the risk significantly by only having that person in when they have direct contact with the person they live with.

So I think there is something about that, whether

it's a scan or whether it's the ability to go into a neonatal ward if babies are particularly ill. So I think there is something about understanding and seeing them as a unit in the way that we did, late in the pandemic, see households as a unit. And so if you see it in those terms, then actually is the risk being increased to an unacceptable level if both of those people come to scans? And I think that's a good example of where you can say the balance should be in favour of both those people attending whether it's neonatal care or scans or actually giving birth.

Q. It means you need to have more PPE in your stockpile going into a pandemic, doesn't it?

A. It certainly would and that is a separate learning lesson for a whole host of reasons, and this is one of them.

Q. All right. A final discrete topic is this. I think you've been provided with a copy of the "Locked out: liberating disabled people's lives and rights" report, which although published in July 2021, looked back over your time as minister, and in that report disabled people certainly reported that their access to going to medical treatment and health services was severely disrupted and lots of disabled people reported they were either in receipt of care or awaiting care and felt

their health had worsened.

During your time as minister, was any specific work done by you or the department to ensure disabled people could access healthcare?

A. Yeah, I think the challenge is that disabled people covers a wide range of people, people with learning disability, people with physical disability, and many of those are core participants, patients in the service. And so, actually, that group were affected as was the whole population. I think the challenge is our understanding about, for example, how you make sure people are still listened to about their care, how they access that care when lots went to remote services, either telephone or on screen, but the fact that people have capacity to make choices as well.

So I understood why people were concerned about that and the regular reports we had from both the Older People's Commissioner, the Human Rights Commissioner, and, indeed, the disability equality groups that we engage with as well.

So there are a range of things we tried to improve as we went through the pandemic but I think, looking back, it's quite important to learn from what you think you got right and not and how that affects current and future practice.

Q. That brings me on to my final question, please, Mr Gething. If you could make one recommendation to her Ladyship for how to improve the healthcare system's response in Wales, beyond having more tests available at the beginning and more PPE in your stockpile, what would your recommendation to her Ladyship be?

A. I think you'd also have to just take out finance, because if you want to improve your estate, you have to spend lots of money on it. I actually think that I've covered this lots in evidence but I think a lot of it is how you make your sure system is as collaborative and as open as possible so you can listen to the real experience of staff and the challenge is how you manage that. And you can't say to tens of thousands of staff, ring the minister up. But it is around culture in the service and I think that really matters. Because you're asking staff to put themselves in harm's way and so how you listen to them and value them I think really does matter.

MS CAREY: Mr Gething, they are all the questions I ask but I think we're now going to turn to some questions from the core participants.

LADY HALLETT: Mr Weatherby.

Questions from MR WEATHERBY KC

MR WEATHERBY: Good afternoon, Mr Gething, can you see and

hear me?

A. I can indeed.

Q. I'm asking you a short number of questions on behalf of Covid-19 Bereaved Families for Justice UK which includes quite a number of families from Wales, and the two topics I'm going to ask you about have been dealt with to some degree by Ms Carey already, so that will allow me to go very quickly.

First of all, shielding. Ms Carey was asking you about the position of shielding in the middle of 2020. And you deal with it in your statement at paragraph 138. And you were explaining that although shielding was paused elsewhere, at 31 July you continued it in Wales until mid-August and you gave us the reasons why. And that was that you you'd been approached by the Disability Equality Forum and there had been concerns about the abrupt stopping of shielding would leave people feeling abandoned. That's right, isn't it?

A. Correct.

Q. The question I have is that you note in your statement that the ending of shielding elsewhere in the UK on 31 July and the position in Wales may have caused confusion, and just this. Did you raise this with the UK Government or other devolved administrations and the concerns that you in Wales had about the abrupt stopping

of shielding and why you weren't? Did you try to come to an arrangement which would have covered -- persuaded the other -- the UK Government in particular to see the point of view that you'd accepted?

A. Well, the problem is that this was an example of where a decision is made and then announced or, essentially, given to devolved governments. And you either decide that there's more benefit in doing the same or you say, actually, I can't and I won't do that. If I decided to go ahead with pausing shielding, essentially two weeks earlier than had already been communicated, without having a conversation with my own stakeholders in Wales, I think that would have led to a lack of trust. So there's more than one thing. The decision isn't just a shielding choice in itself, it's more than that, and I've expressed before some frustration about the way that some UK Government choices for England were made without there being a prior discussion with all four nations.

Q. But that was my question. Did you actually have those discussions with the UK Government or did you just -- were you just frustrated that they hadn't come to you first?

A. Well, I was frustrated and it was certainly part of the health minister's call but once the UK Government

decided to do that, they never changed their mind once they had announced something, if a devolved government had said: we don't think that's the right thing to do.

Q. The second and final topic, PPE. And again, Ms Carey has certainly touched on this. Ms Carey put to you the hospital consultant's email from 24 March, the chaos email, where the consultant was raising with you the lack of protection, and lack of masks in particular for nurses. And then paragraph 317 of your statement you assert that on 21 April you publicly noted that Wales only had enough left in the stockpile for a few days and you also indicate that there was an underestimation of how quick PPE would be used, how rapidly supply chains would fail and that some of the existing stockpile was not fit for purpose.

Looking back on it, given what you said earlier this morning about what we saw on our screens from Italy in February, do you think this is something you should have seen coming and you should have addressed the lack of PPE and the distribution issues that you've touched upon, do you think you should have seen this coming before it was raised by the consultant and before it became -- the shortage actually became apparent on 21 April?

A. I think there's a number of different things. The first

is that, actually, even with the example of northern Italy we still thought we had a pandemic stock that would last for longer than it did, and until we were genuinely having to deal with it directly it was hard to see that that stock wouldn't last as long as it did or, indeed, that the supply lines would collapse in the way that they did, and by the time we got to March, you know, it was then the contracts simply weren't being fulfilled and that gave us a real problem, and with respect, I don't see how we could at that time have anticipated all of that.

The second point I think is that by the time I made the statement in April, I'd seen what was happening, I was able to indicate we'd come within days of running out of some of the items --

Q. Yes.

A. -- but we'd also managed to get mutual aid and more stock in, I was getting over that PPE was a real resource that had to be properly used to protect people and it was something that the Welsh Government was taking a significant amount of interest in.

Q. Yes. But following what you saw on your screens in February, did you actually take any measures in between February and April when you made this announcement in terms of ramping up PPE or checking the

PPE you had or checking the distribution measures that you had in place?

A. Yes, and I think I've been through this with Miss Carey and it's in my statement. So I had had conversations with the senior officials that I worked with about the amount of PPE that we had, the run rate we had on that, when our new supplies were coming -- there's the infamous incident of tracking a plane that came in and landed in Cardiff airport and I think they were supplies from China and Cambodia that we got that were essential to us getting PPE. The failure of a flight in Turkey the UK Government said it had procured. And actually, how we managed was a real concern and a real part of my activity as the minister as well as making sure that we got stuff that was usable.

Q. Yes, but --

A. So it was a significant part of my time, energy and effort.

Q. But that was going forward, presumably from April rather than prior to April, those measures you've just talked about?

A. No, it came from a conversation, not just the email 24 March, but actually it's a growing concern and something that takes up my time through the end of March and April. It isn't just at the end of April that

I suddenly get interested in PPE. I had taken an interest in it because of the reality of how serious an issue it was.

Q. Final point. In Wales the procurement of PPE was a dual approach where you had the four nations basis where the UK acted as the lead purchaser and you had a Wales-based NHS Share Services partnership I think.

A. Correct.

Q. How did you ensure, as minister, that those two parallel systems worked together given what you said about the relationship with the UK Government?

A. So PPE was a significant part of our conversations as ministers across four nations, about where it was and, frankly, whether there was enough trust that the UK was procuring on behalf of the UK, that fair shares would be properly delivered. I don't think the UK Government's procurement mission stood up as well as the one that we were responsible for. Others will have their views, but we eventually managed to not just secure supply lines but we provided mutual aid to other parts of the UK in more significant number, and it mattered because we had to procure not just for the health service but also for social care and at the early stages not everyone at a local level trusted the NHS to get that in because so many local supply lines were collapsing.

So it was not a straightforward or an easy conversation to have either in Wales or with other parts of the UK but we eventually reached a position where there was enough trust between different governments and, crucially, enough supply.

MR WEATHERBY: Yes.

Thank you very much. Those are my questions.

LADY HALLETT: Thank you, Mr Weatherby.

Mr Wagner.

Questions from MR WAGNER

MR WAGNER: Good afternoon, Mr Gething, my name is Adam Wagner and I ask questions on behalf of Clinically Vulnerable Families.

I want to ask you a few questions all about the pause in shielding, and shielding generally. Picking up on the questions that Mr Weatherby asked you about the decision that you took to pause the pause, if I can put it like that, from the end of July to 16 August.

Would you agree that at that time, so in mid-August 2020, there were no vaccines yet, so many of the most vulnerable people remained intensely vulnerable?

A. Yes. If they got Covid they would have been, yes.

Q. And would you also agree that it was around this time that children were going to be going back to school

which would itself increase the risks of the virus spreading and potentially coming back into vulnerable people's households?

A. I guess children going back to school at the start of September was one of the risk factors. It's also worth reflecting, I think Mr Wagner, that in the middle of August to the end of August, Covid rates were at their lowest, so the risk at that point in time and whether it justified continuing with shielding, and if you're going to give people confidence to do a bit more then actually having really low prevalence rates is the time to do that.

Q. Yes, and I'm not going to ask you about the decision itself. But just looking at the risk factors. Do you also agree that the end of shielding would mean that shielding people would no longer be eligible for Statutory Sick Pay when shielding, which would mean they would potentially be forced to return to the workplace?

A. The end of Statutory Sick Pay, yes, that was a factor we weren't in control of, because that's a UK construct. But also it would mean that you'd still have to then consider the individual points about risk assessment for workers (*inaudible-coughing*) as well.

Q. And overall were those all factors that you were taking into account in that decision to pause the pause?

A. It's a rounded choice. It's not one -- it's not a single factor but it is the shielded population, some of them are at work and still working from home, some of them are not able to work at all because of the nature of their jobs. Some of them are worried. Some of them are just keen to get out and about. I'll give you an example. I -- on a brief family holiday I took, we met someone who sold us an icecream and she was saying how well she felt looked after, but she also said that she was shielded but decided she wanted to go to work.

So it wasn't a requirement, it was an offer of support and the advice about the risk. People still have to make their own choices.

Q. And just thinking about those risk factors, did you take or ask anybody in the government to take any particular steps to address those particular concerns or to consider what mitigations could be put in place to ease the process of ending shielding so, for example, psychological assistance or assistance with reasonable adjustments in the workplace?

A. So it was part of the communication about the advice on what to do now shielding has been paused, so they had all had a letter from the CMO, and it was the right choice, I think, that the letter came from the CMO not from me, about why shielding has been paused, what this

means, where they can continue to get advice and support.

The Welsh Government can't do everything in the workplace about reasonable adjustments, for example, because that's an employment construct we're not responsible for legally, but actually in services we are responsible for then, yes, that was already taking place with what we'd asked employers to do and, indeed, dealing with the private sector it wouldn't have been done by me, but the economy minister about asking employers to think about how they deal with the shielded population.

So we couldn't give a directive but there were regular conversations with employer groups around what we would want them to do and we had a couple of instances where we thought there were problems in practice. A soft rather than a hard choice, if you like.

Q. Thank you. And just finally, as you decided to pause shielding and moved away from this approach of guiding people and providing support for them to stay at home, did you consider moving away from that approach towards providing more particular information which could assist clinically extremely vulnerable and clinically vulnerable people in assessing and mitigating their own

risks so, for example, giving them more detailed evidence about the virus, and the kinds of things they could do to avoid the virus like masks, ventilation, those sorts of things?

A. That evidence was made available, so not only CMO's letter directly advising people on steps and measures but when engaging with health services and advice on how to minimise your risk for patients in particular.

So there was advice and the challenge at the time, you know, you couldn't move without hearing about Covid, and of the clinically extremely vulnerable people that I met, they took very seriously the risk they had and the choices they made.

If there is evidence that people didn't know, I'd be interested in how we learn from it.

MR WAGNER: Thank you, those are my questions.

LADY HALLETT: Thank you, Mr Wagner.

Ms Waddoup.

Questions from MS WADDOUP

MS WADDOUP: Good afternoon, Mr Gething, I represent 13 Pregnancy, Baby and Parent Organisations, and I'd like to ask you, if I may, about some of the experiences that disabled pregnant women faced.

Ms Carey briefly touched on the "locked out" report commissioned by the Welsh Government's Disability

Equality Forum. Paragraph 3.25 of that report concluded that maternity provision was uneven across Welsh health boards during the pandemic with particularly significant impacts on disabled women and the report gives us an example of difficulties that disabled pregnant women had in conveying their genuine needs to be accompanied by an advocate or a partner when visiting restrictions were in place. It also highlighted that the provision of after-birth care by phone was particularly difficult for those who were deaf or had hearing loss.

Recommendations were made within that report and included the suggestion that women be allowed to self-register their requirements and that requests for reasonable adjustments are properly formalised to allow for proper consideration of whether a partner or advocate is needed at appointments.

My question, Mr Gething, is this. What specific measures, if any, were put in place to monitor health boards to make sure that they were identifying those women and pregnant people who needed additional care and support?

A. I think there are two points. The first is that the report was published after I was health minister, so the taking forward recommendations would have been for my successor. And, firstly, the detail you're asking

about, the government monitoring that level of detail, that would be pretty unusual and you'd have to have a system in place to do that with lots of reporting.

What we expect is the cultural point about how you listen to women and that the voice of the mother matters about preferences and requirements and the two are different, of course, so -- but to understand what that means in terms of having the best birth experience possible.

So, culturally, I would expect that's what we should do and there's been quite a lot of work done with midwives in particular who want to lead on that cultural change happening for every mother including disabled mothers as well, so -- but there isn't a specific monitoring programme in place for disabled mothers. The monitoring oversight does come from the Chief Nursing Officer, leading with the chief nurse and Chief Midwifery Officer as well, and what is happening in health boards and we intervened in health board areas where we've not been satisfied in practice.

MS WADDOUP: Thank you, Mr Gething.

Thank you, my Lady.

LADY HALLETT: Thank you.

Mr Thomas.

Questions from PROFESSOR THOMAS KC

PROFESSOR THOMAS: Good afternoon, Mr Gething. Can you see and hear me?

A. I can see and hear you now, yes.

Q. I'm representing FEMHO, the Federation of Ethnic Minority Healthcare Organisations.

At paragraph 160 of your statement you note that the risk assessment subgroup concluded that a combination of various factors contributed to the severity of infection including age and ethnicity.

Following this conclusion, were any targeted public health interventions introduced specifically to address health inequalities linked to ethnicity during the pandemic?

A. No. So in my statement I point out that the risk assessment tool was introduced. So this leads from our understanding from the letter from BAPIO, in particular, saying there are problems and there is a disproportionate impact on some ethnic groups. So that's why action is then taken. The risk assessment tool is provided.

On the wider public health challenge we started the pandemic not where I'd want us to be on public health, anyway, and since then our challenge is how we invest in public health and improving public health outcomes.

So I'm not sure if you're asking about wider public health determinants in the population or if you're asking about staff and the work that we did do with the risk assessment tool where ethnicity was a particular factor, and the fact that we knew that it wasn't even -- not every black and brown person had the same risk, but if you look like me or you, you're at a heightened risk compared to some -- a member of the white population; slightly less risk if you are from different ethnic groups but still often a higher risk than the general population.

Q. Given the subgroup's findings, do you believe that addressing health inequality, structural racism and variability in healthcare outcomes should form a core part of pandemic strategy planning going forward in the future?

A. I think it would be sensible to look at those existing healthcare inequalities and the disparity of impact between different ethnic groups. That would be very sensible to do. Even more sensible would be to have this as a standard part of business in the way our healthcare system and wider society works. We know there are different outcomes that are not explained by ethnicity in a positive way -- if you think, for example, of the different experience of black and brown

mothers in childbirth, that isn't to do with the pandemic, but those things can be exacerbated in the pandemic.

Q. Okay. Let me move on. Just coming back on to the subgroup's report. At paragraphs 163 to 164, you highlight the disproportionate impact of the pandemic on ethnic minority communities and the importance of capturing ethnicity-based data included on death certificates. Question: once ethnicity-based data becomes available, how was it used to inform decision-making during the pandemic?

A. So the wider ethnicity data and the improvements didn't really take place in the pandemic. If you look at -- I know you've read the statement. It talks about things have been done afterwards as a result of the report. What we did know, for example, was -- I think I mentioned earlier -- taxi drivers and bus drivers as occupational groups outside the health service with the highest rates of mortality, some of those were about comorbidities, there is an ethnicity factor in that as well. So what we're then looking at is how do we make sure there are measures in place to protect different groups? Taxi drivers, for example, we helped cab drivers to have perspex screens, provide an extra barrier for them in place whilst going about their work,

and the risk assessment tool is an example of what we did in the health service, but it was then adopted in wider public services in particular, including non-devolved services, the police services in Wales were interested in the risk assessment tool and how they could adapt and use it as well, to try to make sure that people could still be in work but redeployed to areas that took account of their risk.

Q. I think you may have touched upon my next question so I'll skip over that and come to my final area, if I may, and this is on engaging with minority ethnic communities.

Did the Welsh Government actively engage with the black, Asian, minority ethnic healthcare workers, health organisations and community leaders to ensure that information about Covid-19 prevention and treatment and healthcare guidance was communicated in a culturally sensitive and accessible way?

A. We did at various points in time. So not just the work of the subgroups that Professor Ogbonna and Professor Keshav Singhal chaired to deliver the risk assessment tool, but that engagement took place -- and I'll give you examples. When we were looking at vaccination, understanding the different cultural sensitivities around vaccination, around different faith

groups, around ensuring that people could have confidence they could take the vaccine, and the work that we did not on a national campaign, some of the discrete campaigns we ran, were about making sure that people didn't just have confidence in the service but we could understand the fears and concerns that people had.

None of that is perfect. I think there are times where other commentators make the mistake of thinking that ethnic minorities are a single community as opposed to a range of different factors you need to take account of. That doesn't mean that we're hard to reach, because we're pretty obvious, it means you've got to make an effort to talk to us in the way you talk with the wider population, and so we definitely did do that and perhaps that example around messaging around vaccination is the best example of a specific communication to try to be culturally sensitive, but I'm always ready to listen and to learn --

Q. Let me come to my last question and it's this. Based on your experience, how could this approach be strengthened to improve engagement and outcomes for minority ethnic communities in future public health emergencies? What can we do better?

A. I think we have got to fix what we do every day, because in the pandemic it's under more stress and strain. You

are making extraordinary choices at a pace that no one is comfortable with. But, actually, if you still have a problem with engagement in the first place, if people think, I'm not sure if I trust the health service in the same way someone else does; if you think, if I go into labour will my choices be respected in the same way as another mother next to me, that affects not just how you feel about the service but affects outcomes as well.

And one of the things we definitely need to do is we do need to take a more serious approach to public health inequalities because they map on to socioeconomic inequalities and they map additionally on to race inequalities as well. So get that right, then I think, actually, you're better geared up to properly deal with a pandemic and recognise -- and lots of infectious diseases have a different effect for different people. Not just age and comorbidities, but race is definitely going to be -- I would be surprised in a future pandemic if race isn't a factor but the least you need to do is to consider it at the outset.

PROFESSOR THOMAS: Thank you, Mr Gething.

Thank you, my Lady.

LADY HALLETT: Thank you, Mr Thomas.

Ms Sivakumaran.

Oh, it's you, Miss Hannett, is it?

MS HANNETT: Sorry, my Lady, there is a degree of confusion between my junior and me, but I am asking the questions this morning.

LADY HALLETT: Thank you.

Questions from MS HANNETT KC

MS HANNETT: Mr Gething, I appear on behalf of the Long Covid groups and we are very grateful to Counsel to the Inquiry who has asked a number of the questions for which we had permission so hopefully I take this relatively shortly.

In particular I wanted to ask you questions, if I may, on Long Covid services. You referred this morning to the rehabilitation framework and in particular in January 2021 you were provided with ministerial advice on Long Covid which stated that health boards will need to avoid over medicalising people and avoid referrals to unnecessary investigations and increasing unnecessary demand on secondary care.

Were you aware that the advice in that ministerial advice prioritising rehabilitation and discouraging referrals for clinical investigation conflicted with the NICE guidelines which recommended clinical management of symptoms of Long Covid?

A. I'm not sure that's a fair characterisation. One of the things we tried to do, and particularly on the journey

particular side has a veto, and it's still about: is a specialist clinic model the appropriate model to deliver the best care across Wales? I wasn't persuaded that it was; neither were my advisers, and I know you've had evidence on this from Judith Paget. But it's still about learning at what point is specialist intervention appropriate and where should that be? Does it need to be in a named Long Covid clinic centre or is it actually about how our service as a whole understands the needs of the population including people living with Long Covid.

Q. In that respect, in this Inquiry, Professors Brightling and Evans, who are the Inquiry's Long Covid experts, have given evidence that they recommend one-stop clinic in Wales, in other words specialist Long Covid clinics, because the complex and novel multi-system nature of Long Covid requires access to a cluster of skills and knowledge in specialist clinics. So, on reflection, in the light of that evidence, do you agree that it would have been appropriate to introduce one-stop clinics in Wales?

A. I think it's appropriate to look at the evidence and then for that evidence to be put before a minister to make a decision. I'm not going to try to insert myself as a clinical decision-maker. I used to be a lawyer,

to having a more prudent healthcare system, is not to overmedicalise conditions where they don't need to be. That doesn't mean that appropriate clinical and medical intervention should not be undertaken.

So I've never considered the advice to say: where medical treatment is appropriate don't do it, try to manage those people away. But it is about how you try to manage the reality of people's symptoms and how rehabilitation, often therapy services, can help to do that effectively. So, with respect, I don't accept the characterisation that you're placing on the advice I received.

Q. You referred also this morning to discussions with patient representative groups and at meetings with the Welsh Government in February and March 2021, so a little after the ministerial advice we've just discussed, Long Covid Wales raised concerns about the management of Long Covid and asked for Long Covid clinics to be provided. Why wasn't the decision not to open Long Covid specific clinics revisited when those concerns were raised?

A. In listening to people you have to understand what they're asking for and why, and what you can deliver in the service to deliver the best sort of outcomes.

Trying to co-produce a model doesn't mean that one

not a doctor, and I'm certainly not a clinical expert now, but it's one of the things you have to do as a minister, is, where there is more than one clinical point of view you have to consider advice and make a choice, and that is a choice for the current health secretary here in Wales.

MS HANNETT: Thank you, my Lady.

Thank you, Mr Gething.

LADY HALLETT: Thank you very much, Ms Hannett.

I think it's Ms Shepherd next.

Questions from MS SHEPHERD

MS SHEPHERD: Good afternoon, Mr Gething. I appear on behalf of Covid-19 Bereaved Families for Justice Cymru.

I am going to start off with the critical care questions and the evidence you gave earlier the system which was that the system did not become overwhelmed. You also said that an indication of an overwhelmed system is people not getting the care when they needed it.

The families that I represent have given examples of their loved ones not being escalated to the level of care they believe would have saved their lives, in particular Paul Jones gave evidence in this module that his daughter Lauren was not escalated from CPAP to ventilation and then to ECMO because there was

insufficient capacity in the system for her to have access to that treatment. That's just one example.

Do you agree that your statement that the system was not overwhelmed is from looking at the data you received but it may not be reflected by the situation on the ground?

A. Well, I think we had the anecdotal evidence that was brought before me today where clinicians said they were making a choice where any might have made a different one in normal times, and I think it's important to reflect on that and what that means. But I never had an instance brought to me where inappropriate choices had been made and that affected outcomes. Being sensitive and understanding how people have suffered loss and bereavement and the question of if something else had happened would my loved one still be here, is important to reflect in way that's sensitive and understands how our whole system works.

So I don't think that changes any of my evidence or the importance of learning from what really did happen.

Q. Professor Fong gave evidence to the Inquiry that the data does not tell the whole story and that it does not always reflect what was happening on the ground. You mentioned the example that was given earlier from the

critical care doctor. If no equivalent study to that of Professor Fong was conducted in Wales, how were you as health minister able to understand whether the data you were receiving gave you an accurate picture of the pressures on the ground?

A. Well, the picture of pressures on the ground is partly driven by the data but it's also the direct conversations and reporting that take place as well. That's with the chief executive of NHS Wales, the Chief Medical Officer, the Deputy Chief Medical Officer, with the chief nurse, with the Chief Scientific Adviser for Health, the therapies adviser, the chairs and chief execs, the direct engagement with unions and medical colleges. So there's quite a lot of information that isn't just about data but it is about experience and what people are doing on the ground. And as a minister you have to try to understand those things and still make choices. The data is always going to matter but I wouldn't disagree with the view that it's not the only thing that matters.

Q. Dealing with the data then, at page 78 of your witness statement you provide screenshots from the daily NHS update showing the critical care capacity in Wales. Did that data show you whether there was the staffing, medicine and other necessary equipment to go with those

beds?

A. No, that would have been a separate report. And again, when we're thinking about staffing, we're thinking about: what responsibility do I have? What responsibility does our system have? And how are we making choices about how the whole system operates?

So the compromises you make on turning off other parts of the system so you can redeploy staff, to make sure the beds are staffed properly in this environment, it was never the physical bed that was the biggest limiting factor, it was always the staff to deliver the care.

And it's also about understanding the additional pressure you're under, which is why we changed -- well, I changed the reporting on how you reflect current potential capacity against normal capacity, show the flex that has been used, and that reflects other parts of the system that are not operating as well.

Q. Do you agree that just because the global figure across Wales for critical care beds was not breached does not mean that all patients received the treatment that they needed at the relevant time?

A. No. I think you're conflating two quite different things. The global figure not being breached showed that we had more capacity to surge into. Whether people

got the appropriate treatment is actually a matter about what was taking place with and for that person. And even in a time where capacity is not breached it's possible for people not to get the care that they need. In the pandemic, and understanding what we were doing and why, it was never brought to my attention, with an individual example or a complaint from not just leaders but the different groups that I met with, that people were not getting critical care they needed that would have made a difference. That doesn't mean it didn't happen but it certainly was never brought to my attention as far as I recall, counsel.

Q. Thank you. I'm going to move on to testing now.

To your paragraph 304, you confirm that you announced the policy of routine testing of asymptomatic healthcare workers on 4 December 2020. The UK made that announcement over two weeks earlier, on 16 November 2020. Why was there a delay in Wales?

A. Sorry, you said about 16 November?

Q. So it was 16 November when it was announced in the UK, and England. And it was 4 December in Wales.

A. I think you've had an answer on this from previous evidence about LAMP technology being used in England that we didn't have in Wales. So we were able to do this when lateral flow devices were in large number.

And I think if you look at paragraph 303, I point out the Chief Scientific Adviser had been providing updates on the mass testing programme and the availability of lateral flow devices.

So if we'd understood that lateral flow devices were not going to be available any time in the near future, we might have had to make a choice to invest in the LAMP -- which I think is a laboratory form of tech, and the staff to do that -- that would have meant investing in infrastructure and in staff to do that. That wasn't a practical thing to do within two weeks. When we did then though get access to reliable lateral flow tests, that's when the choice was made, because we could deliver it.

Q. And although that roll-out was due to be rolled out in full from January 2021, evidence has been provided to this Inquiry, particularly from Professor Kloer, that it was not in fact rolled out until mid-March and as late as July 2021 in some cases.

Do you accept that that that that was an unacceptable delay?

A. Yes, that -- I was surprised by that evidence, because I would have expected for something like that that I'd have been made aware and that Welsh Government officials would have been aware as well about the fact that there

was a different choice being made.

As far as I recall, nobody came to me and said, "This isn't happening and nothing is being done about it". So I was surprised at that part of the evidence from Dr Kloer.

Q. A follow-up question on that. Did you do anything to investigate into whether the testing regime was being rolled out in a timely manner by the health boards?

A. Well, I saw all the figures that were coming in about the large numbers of tests that were being done and the availability of workforce, so I could see that more and more healthcare workers were getting tested and what that meant in terms of the availability of staff. And that's particularly important as you move into what was a high prevalence time and a rising tide of Covid infections through December and into January.

So understanding that staff are able to work and have negative results is really important.

Q. If I could have up on the screen, please, INQ000349686.

Just to locate you in this document, it's the report arising from the Senedd's social care and sports committee's inquiry into the impact of the Covid-19 outbreak and its management on health and social care in Wales, and it's dated July 2020.

A number of recommendations are made, and in

particular at page 45 of this document we have recommendations 7 and 8.

Recommendation 7:

"The Welsh Government, working with NHS Wales, must develop a clear plan for regular and repeated testing of health and social care staff, including asymptomatic staff."

And I won't read out the recommendation in full but it sets out some steps to be taken to ensure that there is sufficient testing capacity. Given that the regular testing regime was not in fact rolled out until spring/summer of 2021 in some cases, do you agree that there was a failure to carry out these recommendations?

A. Well, making a recommendation is one thing. You've actually got to be able to do it.

And, you know, the scrutiny is about a challenge for the government. That doesn't mean that you can automatically deliver testing capacity. And I think in evidence you've heard about how Lighthouse labs in particular went through phases where they were reliable, increased capacity, but actually there were also times where there were real problems that affected the care home sector in particular. So delivering testing, and repeat testing, for health and social care staff is a practical challenge that simply making the

recommendation doesn't actually help you to deliver.

And we didn't actually have the tools to be able to deliver this in the way that's envisaged until lateral flow devices were available. I wish they were available earlier but the simple fact is that they weren't.

Q. I'm going to return then to my last topic of questioning, which is the NHS estate and infrastructure. The chief information officer at Cwm Taf Morgannwg is critical of the inability to extract data from NHS systems in Wales and states that by 24 March 2020 daily laboratory reports were available for NHS sites that could be linked to other hospital datasets but no consideration was given to differentiating community from hospital-acquired infection.

Do you agree that the data collection and processing systems in Wales were insufficient to meet the demands of the pandemic?

A. Well, everyone in our system had to shift. And so, for the pandemic that we faced, what we had, it wasn't sufficient when we started.

And, look, I think the information officer is a high quality public servant who is making a point around what we need to do to improve, but that's the point of it, isn't it? About how you understand what

you can't do but will help you to deliver something better. So not being able to link those different parts was important for us to understand healthcare-acquired infection and community infection. Not the only thing but it would certainly have helped us.

Q. You spoke earlier about the challenges that the ageing NHS estate in Wales posed for ventilation. When the pandemic struck in January of 2020 you had had a health portfolio since September 2014. What steps had you taken prior to the pandemic to improve the ageing NHS Wales estate?

A. Well, we'd undertaken a number of investments. So the way that healthcare capital works, and I think Dr Goodall has given you some evidence on this as well, is both the amount but then how it's then allocated, what the government supports and allocates, with business cases that are made to us by health boards, and discretionary capital that health boards themselves use. Now that is really often about maintenance. And, you know, there's a significant maintenance challenge in the estate because of the amount and the age of the wider estate. There are some invest to -- invest to save opportunities as well, and those normally require approval at a ministerial level to -- but those are more often to about delivering the more efficient service

rather than spending more money, to keep the service running and to deliver improvements in it.

So once I had made the choice early in the term to approve the Grange University Hospital, an awful lot of our available health capital had been spent, so the size of the capital we have available to us helps to govern the sort of choices we can make.

I think in Glangwili, for example, I had overseen and had agreed capital expenditure on improving neonatal provision there. That was particularly useful when it came to parts of the pandemic but that wasn't the reason why I approved it.

So in each of those areas you have to make the best choice available with the resource you have, and as you know, our capital budgets have been reduced in real terms and in cash terms at various points in time overall during my time in the government. And that's the unavoidable truth of the matter. I wish we had more money but we did what we did with the funds we had.

Q. Those are the long-term measures. What urgent measures did you take to minimise the impact of the ageing NHS estate on the ability to implement IPC measures during the pandemic?

A. So I think, again, you've heard evidence on this from others, including Dr Atherton and Jean Wright, an

example being introducing perspex screens. And that's because, if you think about -- and I go back to earlier evidence on this -- Glangwili hospital is the oldest district general hospital in NHS Wales. So you compare that to the Grange hospital, where you have individual rooms where infection prevention and control should be a much easier thing to do in terms of the shape of the estate.

Now, you can't simply build a new hospital without having the money to do it, and you can't simply say we're closing Glangwili during the pandemic. So to do that you've got to compromise, and so the perspex screens that were installed were a compromise to try to improve IPC practice, to have separation between patients. You've also got things like the way that washing facilities are delivered and shared.

So as our estate has been modernised and retrofitted, you'll see improved IPC practice, for example, in the new Prince Charles Hospital -- well, I say "new", it's been significantly refurbished. Still on the same footprint but the changes in the layout should improve patient experience and IPC, as well as new services that were not envisaged when that hospital was originally built.

Q. This morning you discussed how there isn't a control and

command arrangement in Wales. Do you think that the Welsh healthcare system set-up, namely where the health boards and trusts have sovereignty and operational control, led to difficulties in ensuring implementation of IPC measures across all health boards and trusts in a uniform manner?

A. I think the challenge is if you simply say "We'll have a central command and control where someone in Cardiff will tell everyone what to do and they must do it" -- you can do that with directions. It doesn't mean you get compliance. It doesn't mean you get good practice. It doesn't mean you get the culture you need in organisations.

I think our model is broadly the right one but it is how you make sure that model works. How, when people are making different choices, that they're clear about the fact they're making different choices through their own executive infrastructure and at board level. And on issues like this in the pandemic, how that is properly communicated to Welsh Government so it doesn't end of being a surprise. It doesn't mean that that will be the wrong choice though.

When you come back to some of the questions I was asked earlier -- the situation in Withybush, in Pembrokeshire, was markedly different to the situation

in Wrexham Maelor at various points in the pandemic -- trying to tell people what they must do, regardless of local circumstances, is not something that can always work.

And IPC measures, though, I think the rigour that is attached to those is something where you still are going to need local leadership and local -- not just expertise but local cultural agreement that that's the right thing to do for staff and patients. Even if I made all those choices in my office in Cardiff.

MS SHEPHERD: Diolch yn fawr. Those are my questions. Thank you, my Lady.

LADY HALLETT: Thank you very much, Ms Shepherd.

Thank you very much indeed, Mr Gething. It's obvious you spent some time preparing to give evidence and I'm really grateful to you for taking that trouble and for helping us today.

I can't guarantee we won't ask you to come back but I promise you we'll limit the burden we place on you as much as we can. Thank you for your help.

THE WITNESS: Diolch yn fawr iawn, my Lady. Thank you.

(The witness withdrew)

LADY HALLETT: Very well, I shall return at 1.55.

(12.58 pm)

(The short adjournment)

(1.55 pm)

LADY HALLETT: Ms Nield.

MS NIELD: My Lady, please may I call Baroness Eluned Morgan.

BARONESS ELUNED MORGAN (sworn)

LADY HALLETT: Baroness Morgan, I know how busy you must be, and I promise you we will finish your evidence today so you can get back to your other duties.

THE WITNESS: Thank you.

Questions from COUNSEL TO THE INQUIRY

MS NIELD: Can you give your full name, please.

A. Eluned Morgan.

Q. Baroness Morgan, prior to becoming the First Minister of Wales, you were the Minister for Health and Social Services from May 2021 to March 2024; is that correct?

A. That's correct.

Q. I think prior to that role you served as the Minister for Mental Health, Wellbeing and Welsh Language from October 2020 to May of 2021; is that right?

A. That's correct.

Q. And I think when the pandemic began you were the Minister for International Relations and the Welsh Language, a role that you held from December 2018 to October 2020; is that right?

A. That's correct.

Q. If we can begin today considering the period when you first came into the role of Minister for Health and Social Services in May 2021, so at this point the second wave of Covid had ended and Covid-19 rates in the community were relatively low at that point.

In relation to health rather than social services, that aspect of your portfolio, what were your priorities when you became Minister for Health and Social Services and how did you identify those priorities?

A. Well, I was still very aware that we needed to continue with the vaccination programme, so that was important. I was very aware that we needed to switch the planned care programme back on, to get back up to speed. There were issues in relation to social care. I was very concerned about Long Covid and the need to make sure we had a good programme in relation to that. I was concerned about making sure that Test, Trace, Protect was still in place when we needed it.

So those are some of the key things that I was focused on.

Q. And did you identify those priorities because of what you knew already from working in government or was it your officials within the Welsh Government, Civil Service effectively, who identified those priorities to you?

A. So I had a meeting when I first started with the director general of health, who ran through a whole series of challenges that were facing the NHS, and they were numerous, so it was a question then of where do you focus your priorities, where do you focus the attention. I mean, this is a huge brief and it's very difficult to get your head around such of lot of things. So it made sense to try to focus.

Q. If we can look at your powers and responsibilities as Minister for Health and Social Services, and you set out in your witness statement the various areas for which you had responsibility, but you explain that, in terms of the healthcare system in Wales, operational decision-making was the responsibility of the local health boards and the NHS trusts, who had a broad discretion to formulate their own policies, and that your role as minister was limited to focusing on the strategic direction of the healthcare system, approving the health board plans and providing funding. And this Inquiry has heard from the director general at the time, Andrew Goodall, who explained that, as minister, you retained responsibility in a health emergency for preparedness, capacity and increasing capacity and resilience.

We also heard that there isn't a central health

emergency organisation that can take national command and control of the healthcare system in Wales. And so can you help us with this, do you think, with your experience having been the minister during the latter part of the pandemic, would there be benefit, in a pandemic situation, either for the Welsh Government to have some greater powers to direct the response of the healthcare system or for some other national body to be able to take command and control of the NHS to co-ordinate the pandemic response?

A. I think some of that was done centrally, so the vaccination roll-out, for example, was very much centrally driven but now, by now, there is an NHS Executive that exists that didn't exist at the time, so that centralised approach is something that's been developed since then.

Q. I think it's right that the NHS Executive doesn't have statutory powers so it doesn't have the powers to direct the healthcare system, is that right, or is it the minister can use the NHS Executive effectively to give ministerial directions?

A. So we can -- there are methods of ensuring that the NHS health boards do what we want them to do, including through the framework and including, obviously, through financial means. So we have accountability mechanisms

as well so have regular meetings with the health board chairs. And certainly later on I was holding them to account in a very detailed way in terms of what was being delivered.

So accountability is certainly something that I noticed needed to be tightened up and since then there's been an accountability review.

Q. Thank you. You also explained in your witness statement that in the discharge of your ministerial responsibilities for the healthcare system you relied heavily on the advice from the Chief Medical Officer, the Chief Nursing Officer and also the Director General of the Health and Social Services Group.

Did you always feel that you had the information that you needed or did you ever feel that you needed more specific expertise or detailed information on a particular topic?

A. I think in retrospect I'd have liked to have other views, and that's one of the things that I developed since, was to get to set up a system where we have a ministerial advisory group made up of people who are outside the system, including people from -- who are outside, from England, who are kind of kicking the tyres on how we do things. I think that's something perhaps -- it was very difficult.

Sometimes if you're not in a pandemic you can get to the front line and you can speak to people on the front line and get a sense of what's happening from the front line. It's more difficult in a pandemic because there were rules about who should be going into hospitals. So that kind of triangulation that you can do usually.

But obviously we did have advice and I spoke regularly to different organisations. BMA and lots and lots of organisations were coming in regularly, just obviously on online.

Q. Can we have a look at some of the information and data that was made available to you in terms of hospital capacity first of all. And I think it's right that you received regular emails about hospital capacity, which included a table of the available and occupied beds.

And if we can have a look at one of the example emails that you've provided to the Inquiry. [INQ000479978] Thank you.

This is from 16 June 2021, and we can see there this is an "update from Andrew". I think that will be Andrew Goodall, I assume, the "Minister NHS update for 16 [June]":

"The NHS has had a busier week and started with some visible pressures on Monday, with at one point

7 Level 3 sites. Yesterday felt particularly difficult and consistently across Wales -- with high 'normal' levels of activity and evidence of long handover delays and constraints on patient flow ..."

And says:

"This morning still reported 7 level 4 sites ..."

The Inquiry has heard about different levels in different mechanisms, CRITCON, and so on and so forth. Do you know what level 4 sites meant in this context?

A. Yeah. I think it's probably worth noting I'd only been in the job a month when this was sent, so I was really trying to learn how the system worked and I wasn't too familiar with how the levels were set, which is why I asked the question, and I didn't quite understand how they could say that some of them were at perhaps a lower level than I expected sometimes, because I knew there was a lot of planned care pressure. But this was about urgent pressure, it was about day-to-day pressure and that's what this particular approach -- the escalation process is about the day-to-day and the pressure on the system on the day, rather than the kind of more planned care concerns that I was starting to be worried about.

Q. So can you help us, what does level 4 mean in that context?

A. So level 4 means that they are already using the additional bed capacity that needed to be used but level 5 would be the one where actually everybody is in, everybody has their leave cancelled, everybody -- so this was one down from that. But, you know, level 4 was pretty consistent in many places for a long time, and indeed even today the pressures are huge and we have pretty consistent level 4 levels still.

Q. If we can go over the page on that email, please, we can see the table and we've seen a similar table from earlier both in March and in April of 2020, prepared by Andrew Goodall when he gave his evidence, but we can see that the numerical data that you're provided with at this point, and this is really between waves 2 and 3, in June of 2021, and so we can see that you're shown there the number of available beds in critical care and the occupied beds in critical care and how many of those occupied beds are occupied by Covid-19 patients. We can see there is only one Covid-19 patient in critical care at that time.

And we can also see under "Total Beds", on the right-hand side, number of non-Covid-19 occupied beds, there are just over 8,000 occupied non-Covid-19 beds. This is outside of critical care, non-critical care it would appear.

In terms of what isn't shown on that, it doesn't appear from this that you're told what proportion of the non-critical care beds are occupied. We can see that critical care beds occupied 72% but you're not told how much available capacity there is for non-critical care. Would that have been useful for you to know apart from just knowing that you're at level -- that the sites were at level 4? Would it have been useful to know quite how full the general acute capacity was in Welsh hospitals?

A. I remember on a -- certainly on a weekly basis monitoring this quite closely and just trying to work out how near to capacity we were. So although it might not have been on this particular graph, I remember the note being clear about how many critical care beds we had, and therefore you can work out pretty quickly how many were available to us.

Q. And what about the non-critical care beds, the other activity, of the -- just the general acute beds that would be on a normal acute ward? Would it have been helpful to know how many of those were unoccupied? I think you're only given on here, it appears, just the number of beds that were occupied.

A. I was very aware that we were very much near capacity.

Q. This table also doesn't give any idea of whether those critical care beds are level 2 or level 3. We've heard

about that differentiation. It's intensive care or high dependency care and the staffing ratios that differentiate between those two levels of care, and indeed there isn't any information on this about what staffing ratios are having to be employed, which is another measure of surge capacity and how stretched the critical care units might have been.

Albeit that this is at a time between the Covid surges, by the time that the Omicron surge hit in Wales, would it have been useful to know about staffing ratios in critical care, or indeed the number of patients receiving CPAP, for example, outside of critical care? That's something that we saw that had been -- that data had been collected earlier in the pandemic. It doesn't seem to be here. Were you ever given any information about patients receiving -- Covid patients receiving CPAP and how close that was to capacity?

A. I can't remember getting that information on CPAP but if you look at the number of Covid-19 patients in occupied beds, you know, they were actually quite low.

Q. At this point, yes, but later in the pandemic when the Omicron wave hit --

A. Sure.

Q. -- and there were more patients hospitalised, were the data categories -- did they change at that point, when

there were more Covid patients? Were you given more detail about the kind of clinical support that was available for Covid patients?

A. I can't remember getting that information at that time, no. But I was aware that there was a lot of pressure in terms of staffing in critical care, and I was aware, particularly later, that there were difficulties in recruiting to emergency departments in particular and critical care as well.

Q. I think also on here we can't see whether there are any beds available in field hospitals. Were you given information about any available beds in field hospitals, was that something that you were given regular updates on?

A. No, because I think the kind of -- I think they were included in the health boards' numbers so, you know, there was a surge capacity, effectively, which was counted in these numbers.

Q. Thank you. Aside from this sort of numerical data then, you mentioned before about how difficult it was to go into hospitals and find out what was happening on the ground. How did you hear from frontline healthcare workers about the pressures on the ground aside from the numbers?

A. So as soon as I was able to enter hospitals I used to do

a lot of unannounced visits, I used to just turn up at hospitals, and get a sense from patients waiting how long they had been waiting. I'd manage, in particular, to go into emergency departments and to listen to what people on the front line were saying, and they were always really pleased because quite often if you turn up as a minister they've cleared everything up before you arrive. But what I got was a much more authentic view on pressures and what was going on and I think it was really appreciated because it meant that I could speak to them. You know, if you go in and you're surrounded by 15 managers you don't get to the people who are actually coping with it day in, day out.

And I found that really useful. I did it around Wales quite a lot as soon as I was able to get into hospitals when the levels of the infections had reduced.

Q. And did the picture that you -- that emerged from speaking to those people when you went to visit hospitals, was that a picture that was in contrast to the information you were getting from the purely numerical data, or did those two things marry up?

A. They definitely married up but what you don't get from numbers is a sense of how people are feeling on the front line, of the pressure they're under, of the intense -- intensity of the work that they're

undertaking. I even went out and spent the day as an ambulance worker with the ambulance drivers and, you know, there were people who were breaking down and it really brings it home to you when you realise the pressure they're under. No graph is going to tell you that.

Q. The Inquiry has heard repeatedly that there was a focus in all four nations of the UK on ensuring that the NHS was not overwhelmed. What did you understand "overwhelmed" to mean? What would your measure of the NHS being overwhelmed to be?

A. I guess there's different ways of describing what "overwhelmed" means. Did we have enough beds? I don't we never ran out of beds but were the people working in the NHS overwhelmed? Yeah, I think there were a lot of people who were working in the NHS who were definitely overwhelmed and I'll never forget speaking to some of the people on the front line about how they were feeling, they were breaking down, and there was a group who came to present at the Senedd, the Royal College of Emergency Medicine, they came to the Senedd and it was really harrowing to hear what they had been going through and how clearly traumatised they were.

Q. Can we move on to a new topic, please, and that's nosocomial infections and IPC measures, infection

prevention and control measures in Welsh hospitals.

In your witness statement the first briefing on nosocomial infection rates that you identify is from 30 June 2021. Do you know whether that was the first time that particular issue had been brought to your attention as health minister?

A. Yes, I'd been in post about a month and a half by that point.

Q. And if we can have a look, please, at the briefing that you were provided with at that time.

We can see that Public Health Wales data for 1 March 2020 to 30 May 2021 indicates 7,127 probable and definite nosocomial Covid-19 infections in Welsh hospitals.

And on page 2 we can see that:

"Health board self-reported data to the Welsh Government outbreak reporting system indicated that from 23 November to 23 June 2021, during the 'second wave', there were 232 outbreaks in Welsh hospitals in which 3387 patients and 1360 members of staff tested positive for COVID-19."

And then we see below that that there's a note that:

"All nosocomial Covid-19 infections are 'incidents of patient safety' and therefore health bodies are

obliged to investigate these under Putting Things Right."

I think that was a pre-existing process that existed for patient safety investigations in Wales.

And then below that we can see that there's reference to the national framework on managing patient safety incidents following nosocomial transmission that requires health body to contact patients or their families where harm has been caused.

And then there's a note that potential claim values vary widely. Initial estimates range from £7.7 million to £69 million.

Do you think that this focus on the cost of potential civil claims arising from individual cases rather than adopting a no-blame culture may have deterred local health boards from candour and openness when they were trying to tackle this ongoing problem of nosocomial transmission in Welsh hospitals?

A. Well, I certainly wasn't aware of a focus on money. I think the focus was far more on how do we make sure this doesn't happen again and trying to learn lessons from the fact that we had high levels of transmission within hospitals. So I am surprised that -- I'd like to think that they weren't focused on money but they were focused on sorting things out so it wouldn't happen

again.
Q. I think it's right, isn't it, that the national nosocomial Covid-19 programme, which was about the way that this national framework had been implemented, and it provided an interim report in August 2023 and a final report in 2024, that framework was developed to ensure that local health boards were investigating individual patient deaths from hospital-acquired Covid as a patient safety incident. Why was there no national investigation into the causes of cluster outbreaks in hospitals or the persistent problem of nosocomial transmission in Welsh hospitals?
A. Well, every single individual case was investigated, 18,630-odd. So every, I think, ours was probably more detailed in terms of why things were happening and trying to make sure that we provided -- that we learnt the lessons and there was a huge amount of work done by the Wales National Framework in terms of making sure that they took account of all of the things that they needed to assess, things like PPE and ventilation and bed spacing and visiting rules, so all of that was in the national framework.

So I think the investigations could not have been more thorough in terms of the numbers of people, every individual being investigated.

Q. But they were investigations into individual cases, weren't they, rather than investigations into the causes of cluster outbreaks within a particular hospital or health board?
A. Yeah, but it's actually really difficult to get to what exactly is the cause because there are potentially lots of causes and what that group did was to look at all of the potential causes.

So to be able to say definitively "This is the precise cause", I think would have been quite difficult.
Q. You've set out in your witness statement that in May of 2022 you were sent and reviewed two public health reports, one of which was called "Lessons learned from nosocomial outbreaks, September 2020-April 2021".

I don't think we need to get that up but it shows that nosocomial infection rates in Welsh hospitals were worse in wave 2 than in wave 1, and the conclusion on page 8 of that report was that not all lessons identified at the end of wave 1 were actioned successfully.

Were you concerned on reading that that this meant nosocomial transmission in Welsh hospitals may have led to a significant number of preventible deaths in wave 2?
A. Well, I think it's important to note that some lessons were learnt, the spread of asymptomatic Covid, for

example. So there were lots of lessons that were learnt, but the fact that we had a follow-up report to find out why they hadn't implemented the recommendations of the first wave is something that probably needs to be explained by the health boards.
Q. What steps did you take as health minister to try to address the problem of nosocomial transmission in Welsh hospitals?
A. Well, we were very strict in terms of visiting. So we had to make sure that those kinds of measures were put in place. There was a lot of support in relation to ventilation by the NHS Wales Specialist Estates Services, because I knew that there were lots of people who thought that we needed -- we had a very old estate and that is very difficult so lots of our wards are open wards, they're not individual wards, and obviously it's much more difficult then to stop the spread.

Making proper use of PPE, making sure that there was good bed distancing, all of those things were things that were brought up in that Wales National Framework so there were opportunities. People knew what they should be doing but actually if you've got quite an old estate it is much more difficult to control the spread than if you are able to isolate people in individual wards.
Q. Given that shielding people and those more clinically

vulnerable to Covid-19 were going to be at higher risk from contracting Covid infection and also likely to be frequent users of healthcare, were there any efforts made to identify or monitor the number of clinically vulnerable and shielding people who had contracted Covid-19 within healthcare settings? Do you know?
A. Well, all of that would have been monitored, I assume, on the ward themselves by the people who were responsible for the operational duties within particular wards, so that should have been on their notes.
Q. You've set out in your witness statement that when the Omicron variant arrived in Wales you were particularly concerned about the impact that this more transmissible variant could have on nosocomial transmission rates. Did you consider at that point that it may be necessary to have a review of IPC measures to ensure that the right protections were in place in hospital settings?
A. It was something that I discussed with the Chief Medical Officer. We did tighten up some of the rules just before Omicron hit so we actually actioned some things prior, you know, as soon as we knew that Omicron was present in the country. So measures were taken at that point.
Q. You mention there that one of the measures you focused on in particular was visiting, in relation to trying to

address nosocomial transmission rates. So if we can look a little at some of the changes that you made to the hospital visiting restrictions when you were minister.

You've set out within your statement that you saw it as quite important to allow local healthcare providers to depart from national guidance on visiting in response to local transmission rates although that would necessarily create some inconsistencies in approach across Wales.

Can I ask you this, did you consider any specific communication strategies or other measures to try to help explain to affected families why these variations were occurring and particularly at points when wider societal restrictions were lifting but visiting restrictions were remaining in place?

A. There was -- there was a huge amount going on at this time and obviously the key thing was to communicate with the people who had to implement the rules. So getting the guidance out to the people responsible for implementing was the most important thing. And then, secondly, obviously, to make sure that those who needed to visit understood why.

But the fact that there was a kind of national guidance but there was a degree of flexibility locally

meant that there was an opportunity for health boards to respond to local circumstances. So, you know, Covid went through in waves around the country and whilst it would have made sense in some areas to tighten things up, and this happened on a number of occasions where health boards just saw a wave coming at them and they tightened everything up, they stopped -- they restricted visiting for a short period and then they loosened up again. And we thought that that approach made sense which gave the flexibility. But obviously there were times when we needed to be sensitive to some specific cases.

Q. Were you provided with or did you request any advice or supporting information from IPC experts about the contribution to nosocomial transmission rates from visitors coming into hospital, to what extent was it the case that visiting restrictions impacted the number of nosocomial transmissions that seemed to be taking place in Welsh hospitals?

A. I think we were really aware because of what we'd seen particularly in care settings that sometimes some care workers moving from place to place actually was part of an increased risk. So if that was true for professional workers then the same would obviously be true for people who were not professional workers, so we were already

sensitive to it, and learning the lessons from the first wave where we saw those -- that happening in some instances.

Q. Can I ask you specifically about visiting guidance for maternity services and for pregnant women. I think you were responsible for amendments to the visiting guidance on 9 May 2022. This was the first time that the guidance specified that a birthing partner was not to be counted as a visitor and this was over a year after England had made this distinction between birthing partners or support, birthing support, and visitors in their guidance. And I would like to ask whether you consider the guidance for Wales should have always specified from the first guidance that birthing partners were partners in care and not to be counted as visitors?

A. If I had my time again, I would definitely have introduced that earlier.

Q. I think -- thank you. Do you consider now, looking back with the benefit of hindsight, that the visiting restrictions generally in Welsh hospitals, not just in relation to maternity, but that they struck the right balance between the benefits to patients of having visitors and supporters, and reducing the infection risks of visiting? Do you feel that the balance was struck in the right place?

A. Not when it came to maternity. I think we also discussed, I remember, as a cabinet, people who were perhaps receiving a diagnosis where it was possible that they'd have cancer, that probably we should have been more flexible in that kind of instance as well.

So I think there are a few instances where we might have done things slightly differently. But the fact that there was a clear national guidance but the flexibility locally to respond, I think that was probably the right thing at the time.

Q. If we can move on to a new topic, please.

You mention that one of your priorities on coming into office was the recovery of elective services and planned care. When you came into post in May 2021, what did you understand to be the primary reasons for the backlog of patients awaiting diagnosis and treatment for conditions other than Covid-19, and what were the main obstacles to recovery of elective care at that time?

A. Well, we've been very clear that the focus should have been on urgent cases, on cancer, and there was huge -- and non-emergency services obviously. And in Wales you have a situation where we don't have many major cities, so it was really difficult to have planned care separate from emergency care. And so emergency care knocked out planned care quite regularly, and that clearly caused

a problem.

But I think, you know, there was lots going on in health at the time, it wasn't just about planned care. In Wales we have 2 million contacts a month, in a population of 3 million people, in the health service. The demand on the service is enormous. And so you have to remember the context of having to keep all of that going at the same time as well.

Q. For winter 2021-2022, the winter plan that you announced for that period was clear that, due to that projected increased pressure on the NHS, the number of patients receiving planned care would reduce. You said this:

"On planned care, we will be straight with the public and explain that it will be tough to work through the high numbers on our waiting lists over the winter, and we may need to flex the system and reduce the numbers receiving planned care treatment if the pressure on the system continues to mount."

Was there any consideration given to using field hospitals or independent sector facilities as elective hubs to enable elective care to continue through that winter?

A. Well, when it came to field hospitals, the issue with field hospitals wasn't the beds it was having the staff to be able to operate the beds. So the problem doesn't

go away just because you can provide field hospitals, you still have to provide the staff. So that was the problem there.

When it came to the private sector, there's got to be an understanding of the number of beds in the private sector in Wales. We have 172 beds in the entire private sector in Wales. So whilst in England I think they used about -- they cleared about 18% of their waiting lists through the private sector, we had 172 beds. So we even -- and we did use the private sector, but obviously there's not much to use there, and we did actually use some private capacity in England as well. So it's not as if we didn't do it, it's just that actually the provision is a long way from Wales, and that definitely made a difference.

Q. Can I ask you about the issue of health inequalities in terms of elective care. You refer in your witness statement to an evidence paper prepared for the Health and Social Care Committee investigation into the impact of the waiting times backlog on people in Wales. That paper I think was prepared in February of 2022, and it noted that investment to increase capacity had not been provided until 2021, and also that deprived areas faced disproportionately large waiting lists per head of population compared with the least deprived areas.

Can I ask whether you took any steps as health minister to address that health inequality in relation to elective care specifically?

A. Well, I mean, that wasn't anything new. The demands -- you know, we have an older, sicker, poorer population, and it is concentrated in various parts of the country. So we went into the pandemic with people in those areas facing longer waiting lists anyway.

I think the other thing to note is, for example, it's quite difficult to recruit sometimes into some of those areas, particularly into rural areas, so -- you know, people -- a lot of medics want to be in cities, and that makes it much more difficult.

And I think the other thing that's worth noting is that the challenges of delayed transfers occur, and that was becoming an increasing problem, particularly if you can't -- if you can't separate out planned care from emergency care, like you can in big cities, where you have two hospitals in a similar area, that is really challenging. So we are developing surgical hubs now but they have to be developed on -- very much on a regional basis rather than it -- within health boards, because there's just -- you know, we just don't have the population base to hold those.

So those have been developed since, are being

developed, but it's a new approach because you need it to happen on a regional basis and that is something fairly new in our system.

Q. The Inquiry has heard from two experts in orthopaedic surgery, Professor Metcalfe and Ms Chloe Scott, and I think a transcript of their evidence has been provided to you. They explain to the Inquiry that the delivery of restoration of elective care in Wales was significantly delayed compared to what was happening in England, and Professor Metcalfe told the Inquiry that the first guidance document on recovery of elective care was -- orthopaedic care was released in 2022, and the Welsh guidance document was much more vague than the NHS England equivalent, and it, importantly, was not linked to any financial incentives. And consequently, treatment delays in Wales were, in the words of Professor Metcalfe, absolutely huge.

Do you think that the Welsh Government should have planned to recover elective care sooner in the pandemic and taken steps to incentivise the local health boards who were able to restore elective services?

A. I do think it would have been better to have perhaps come up with the plan sooner. I'm not sure if it could have been implemented sooner with the pressures that the system was under.

So our system is not one, currently, that is driven by financial incentives. There's an understanding in some quarters that that perhaps sometimes leads to unintended consequences, but I think also that there was a need for not just us to be more deliberate in terms of ensuring that we knew exactly what was going on within these orthopaedic hubs, but, more than that, the health boards needed to know what was going on. So, again, I did one of my unplanned visits to an orthopaedic hub, on a Thursday afternoon, and I found there were 13 surgeons not working. They weren't there. So, you know, the monitoring, the management was not happening in the way that it should have been happening.

Q. That brings me on to my next question, which was whether the Welsh Government monitored elective or planned care during the pandemic. Was it counted separately, if I can put it in that way? Was there a monitoring of how much activity was going on?

A. Well, I initiated very, very careful monthly monitoring, where I asked for details on what was going on, how long the waiting lists were coming -- how quickly the waiting lists were coming down, particularly for those longest waiters. So, you know, I personally got really involved in monitoring what was happening on a monthly basis in

terms of the planned care programme, because it wasn't going in the way that I'd hoped.

Q. Do you think that future pandemic plans should include a specific strategy for the continuation or at least the prompt recovery of elective care?

A. I think having a plan is easier than actually making it happen, particularly if you can't separate out planned care from emergency care. And that was one of the real difficulties for us. You know, we didn't have the private hospitals to the extent they did elsewhere. We didn't have the orthopaedic hubs, although, you know, the orthopaedic surgeons gave really clear direction in terms of what they wanted to happen. But again, you know, I visited the -- one of the few orthopaedic hubs that we had, and they weren't working. So, you know, I do think people have to be held to account within a system.

LADY HALLETT: Did you discover why they weren't working? Forgive me, I'm losing my voice.

A. I did -- I was given an explanation.

LADY HALLETT: It sounds as if you didn't accept it.

A. It wasn't what I expected to see and I took steps afterwards to make it clear that things had to change.

LADY HALLETT: So it wasn't that they were off sick or anything?

A. They were not.

LADY HALLETT: Whatever the explanation was, it was not a satisfactory one?

A. It was not a satisfactory one.

I'm happy to send, perhaps, the letter that I wrote, to you. It might be of interest.

MS NIELD: If we can move on then to some questions, please, about shielding. I think it's right that the shielding programme in Wales was paused in March of 2021, so it was paused when you came into post as Minister for Health and Social Services. And, in fact, it wasn't reinstated during your tenure as minister, I think that's right, but I think there were, certainly at least two occasions, when you received advice from the Chief Medical Officer for Wales as to the position of people on the shielded patients list and you were given the -- given some advice or some options about either reinstating the shielded patients list or, indeed, closing the shielded patients list.

I think in July of 2021, in the light of the planned relaxations for the general community, in terms of Covid restrictions being relaxed, the Chief Medical Officer advised you that the shielding programme should not be reinstated but he intended to write to the clinically extremely vulnerable advising them to take

extra care to minimise their exposure to the infection, to meet outside where possible, keep contacts to a minimum, and to continue social distancing.

Why did you not consider it advisable to reinstate shielding at that point if the lifting of restrictions in the general community may place those people at greater risk?

A. Well, because by this point they'd been vaccinated so they had a degree of protection and this was really just a precaution for them to give them more confidence to know, look, actually, we know that things are going to open up, that there is a potential for it to spread. This was happening in the summer, so it was less likely to spread than in the winter, but we just wanted to give them confidence and to give them reassurance that these are the measures you can take if you do want to protect yourself, because it wasn't a one-way thing. There were some people who were really concerned because of their vulnerable and they needed to be given that additional guidance in terms of what might help them to avoid contracting the virus despite being vaccinated.

Q. Were the steps set out by the Chief Medical Officer that I've outlined not effectively advising those who had been on the shielding list to continue to shield but simply without any government support to do so?

A. No, we weren't advising them to continue to shield, we were giving them tips on -- the Chief Medical Officer was giving them tips on how to avoid obvious things, like, don't go to a disco, just kind of a common-sense approach, I think, just reminding them of how mixing with people, in particular in close-set environments was likely to increase their risk of contracting the virus.

Q. I think it's right that in December of 2021 Rebecca Evans, a member of Senedd, wrote to you with a request to reinstate the shielding programme in the light of the concerns about the emergence of the Omicron variant. And in that letter she stated that vaccination is only effective in 40% of the clinically extremely vulnerable. I think on that occasion the Chief Medical Officer of Wales again wrote to those on the shielded patient list reiterating the advice to take extra precautions but the shielding programme was not reinstated at that point.

Did you consider whether this might be, with the emergence of the Omicron variant in the middle of winter 2021, that this might be a time when it would be appropriate to reinstate the shielding programme?

A. I got advice from the Chief Medical Officer. I think it's probably worth noting at the time we weren't sure how Omicron would affect people. I think there was a degree of confidence that the vaccine would be able to

withstand Omicron but the letter was, once again, to give them reassurance and by now, of course, we had the retrovirals as well that could be given if they did contract the virus.

Q. In the light of the concerns that those who were severely immunosuppressed and may not be able to take the vaccine or the vaccine may be less effective in those people, was there any consideration given to extending the shielding programme with all the protections that that had, for example access to Statutory Sick Pay and so on, for those -- for that cohort within the shielded patient list, so those who were severely immunosuppressed?

A. It was considered by the Chief Medical Officer. Of course, by now, it had already been dismantled in England so, you know, we thought that it made sense for us to again give them advice on how they should protect themselves.

Q. You've referred in your witness statement to having to balance the benefits of shielding against the disbenefits such as social isolation, and so on, when you were deciding whether to reinstate the programme. Beyond the concerns of individual constituents being brought to your attention by members of the Senedd, did you seek to ascertain the views or ask your officials to

ascertain the views of the clinically extremely vulnerable in terms of the impact on them of being asked to shield or indeed of pausing the shielding programme?

A. Well, before becoming health minister, I was the minister for mental health, and we knew that there were a lot of people who had been suffering, particularly younger people, as a result of the need for them to self-isolate. So it was a question of balancing.

In terms of the clinically extremely vulnerable, then that was -- the CMO would have been looking into that.

Q. Can we come on, please, to look at Long Covid.

You've explained in your witness statement that by the time you were appointed Minister for Health and Social Services, there were established systems and processes already in place across the NHS in Wales for the management of Long Covid. And you've explained that you received advice in June of 2021 that funding of £5 million was required to support the expansion and development of primary and community services for those recovering from the effects of Covid-19.

Do you think that the funding should have been made available earlier than June of 2021?

A. Look, I can only speak for myself. I was appointed in May. It was an area where I felt we probably needed to

do a little bit more work, and within a month we had a new programme. We had £5 million in that programme.

I think I was really sensitive to it because my brother-in-law had been suffering with it, so I was probably more attuned to it and thought that we needed to do a bit more work in that space.

Q. In terms of the model of clinical support for people with Long Covid in Wales, I think you've been provided with the Public Health Wales International Horizon Scanning Report which was published in May of 2021, which advised that the multidisciplinary approach to assessment and management and patient involvement are all instrumental in addressing Long Covid.

Would you agree that the existing system that was in place when you became minister in May 2021 was not providing a multidisciplinary approach to assessment and management of Long Covid?

A. I think we were still trying to work out what Long Covid was. One of the first things I did was to visit a multidisciplinary -- it wasn't a clinic, it was being carried out in a sports centre where several different therapists were brought together, and in fact I visited two of those as the project continued. So that multidisciplinary process, I don't know what was there before but it was certainly being developed very quickly

after my appointment.
Q. I think that the programme that was developed, the Adferiad programme that was developed, was reviewed every six months and the local health boards were required to submit reports on that, is that correct?
A. Mm-hm.
Q. I think the first report was in January 2022, which you've summarised in your report.
Is it right that that report also showed that some local health boards did not start offering services until December of 2021, and did you have any concerns that there seemed to be inconsistency across the local health boards in Wales as to the services that were being provided for people with Long Covid?
A. First of all, in terms of Adferiad, "adferiad" means recovery in Welsh. Long Covid, we were all learning about Long Covid, and I was clear if we can start a new programme on a condition that people don't know much about, we should make sure that we're reviewing it all the time, because the science was changing, the evidence was changing, we needed to keep up. So that was absolutely central to the programme, is that we had to just keep on updating it and finding out was it -- was it addressing the issues, was it being effective, and was it keeping up with the science. And at the same

time we put about -- I think about 700,000 into research on Long Covid as well.
But just in terms of the money and when it was being influenced, this came in in June. The money didn't hit the ground until, you know, July, and so, it -- you know, it's not something you can switch on overnight if you've got multidisciplinary teams that you need to pull together.
So I'm sure that some were further ahead prior to the programme.
Q. The Inquiry has heard from two specialists in Long Covid, Professors Brightling and Evans. And again, I think transcripts of their evidence has been provided to you.
Professors Brightling and Evans told the Inquiry that the gold standard for Long Covid care is a multidisciplinary team clinic which is a one-stop shop for patients, and that that hadn't been adopted in Wales, and furthermore that the variation between local health boards in the services for Long Covid was a disservice to patients in Wales.
Was any consideration given to adopting Long Covid clinics as evidence emerged of their clinical and cost-effectiveness?
A. Well, the way NHS is organised is very much community

based. It is a model that is in keeping with our strategic plan, A Healthier Wales. Very interesting to see that Lord Darzi is now recommending that's what should happen in England. And so we needed to provide a model that worked within the structures that we have within Wales, and those structures are always to try to give support as close as you can to where people live.
So there was a mechanism, via a GP -- we made sure everybody knew what the pathway should be -- via the GP, into the multidisciplinary teams, and then on, if necessary, to specialist support services. And what we found when we assessed the programme was that there was a very high degree of satisfaction from the people who used the services. I think 87% of people said that they would recommend it and that only about 3.5% of people were referred on to those -- to secondary care, effectively, who needed that real specialist support.
Q. I think the January 2022 report referred to those results from the CEDAR evaluation study that you've referred to. Were you aware that that CEDAR evaluation study, there was a survey of patients, also included some negative feedback? Nearly 30% of existing service users rated the Long Covid services in Wales as average or below and that some existing users felt that treatment was too generic and the service was not

helpful overall?
A. Well, you obviously can work out if you've got, you know, 83% who would recommend it to their friends -- or 70% of people who are satisfied that there's 30% who had not satisfied. So, I mean, there's still people suffering with Long Covid today and, you know, they haven't had the answers that -- and the results that they'd hoped. So, you know, I can see why they would feel frustrated. I'd be surprised if you'd get to 100% satisfaction with specialised Covid clinics.
Q. If we can move on, please, to look at primary care and the changes made in primary care during the pandemic.
There was a perception that people could not get an appointment to see their GP and that face-to-face appointments had been stopped entirely. What do you think caused that perception and could more have been done to dispel that perception?
A. I think at the beginning, you know, people thought everything had shut down and there was an opportunity -- I was married to a GP -- I am married to a GP, who was on the front line every single day, so I was very aware that he was going into work, as were all of his colleagues. That perhaps wasn't something that was recognised by the rest of the public. But we made it very clear that, you know, GP surgeries were open,

albeit not in the usual way. So, you know, for a long time they weren't doing face to face but they were doing online consultations, they were doing telephone consultations.

And one of the things we did in Wales is to make sure we continued with that understanding that actually you're not going to get a face-to-face appointment with a GP every time you ask for one because actually the system worked quite well for other people.

And since then we've changed the GP contract in Wales so that we've got rid of lots of the issues that exist elsewhere and existed before because we've changed that contract.

Q. Did you take any steps as health minister to ensure that GP surgeries in Wales were making face-to-face appointments available for those patients who needed them?

A. So it was up to the clinicians, to the GPs themselves to determine and to do the triaging in terms of who needed to come in. I don't think it would be appropriate for a politician to say, you know, these are the people who need to come in, these are the people who need to be seen. You know, that is the job of a clinician, and they had to do that risk assessment themselves.

Q. Do you think the Welsh Government made it clear enough

to GPs that they had to continue to offer those face-to-face services for some patients?

A. I think we did make it clear. We're very aware in Welsh Government of the equalities issues and the difficulties perhaps, in particular, of older people who perhaps found it difficult to have some of those conversations on the telephone or not face to face. So that should always have been a service that was available.

I'm not sure if I'm aware of any who didn't provide that but they are the ones who had to determine who should come in and who shouldn't.

Q. I'd like to move on, please, if we may, to a new topic: DNACPR notices and concerns about blanket or inappropriate application of those notices.

I think it's right that on 1 February 2022 you were informed by Mike Hedges, a member of Senedd -- this is at paragraph 292 of your witness statement. Mr Hedges was informing you of the concerns of the Covid bereaved group that DNACPR notices had been issued for their loved ones without any discussion with the relatives. And you made a written response, I think, to Mr Hedges which referred to the All Wales DNACPR policy and the fact that that policy explained there should be, always, consultation with those concerned when a DNACPR notice was being considered.

Given that the report of Mr Hedges was clearly that that All Wales DNACPR policy had not been complied with, did you obtain any further details from him to investigate where and how those specific incidents that he was complaining about had occurred?

A. I can't remember if I -- I can't remember. I'm sure that we would have followed that up but I'd like to have the opportunity just to make sure that that is what happened. Because I was -- I know I was really concerned about it and concerned about any instance where there was a suggestion that that happened. Because we had a very clear policy on this, so clearly if that was happening they were not following the guidance that we put in place. And we had had a report by Health Inspectorate Wales who had done a sample review and they didn't raise any issues at the time and I know there was kind of -- they were very keen to make sure there was personalised and compassionate communication.

Q. Can you help us, please, with when that Health Inspectorate Wales sample review took place? The Inquiry has heard that there was a review that was announced, I think, in October of 2023. Was this a review that took place during the pandemic?

A. I think there was one that took -- if you wouldn't mind,

I'd like to check that rather than give you something that will mislead you.

Q. Thank you.

You've also referred in your witness statement to another written question from a member of Senedd, Russell George a couple of months later, in April of 2022. Again, concerns about DNACPR.

And can we have a look at your written response, INQ000480092. And you respond in this way:

"I am aware that there have been some high profile media reports of blanket DNACPRs being applied and have been notified of some isolated incidents where it is alleged that DNACPR policy has not been followed."

You go on in your witness statement to explain that you're referring to the incidents that triggered the letter from the CMO and the CNO of Wales.

You said that:

"The Welsh Government takes these allegations very seriously and in each case has acted promptly to investigate and seek confirmation of the governance and assurance processes in place within the relevant health board to ensure these decisions are taken in line with extant clinical guidance."

Wasn't the issue here not that there wasn't any

appropriate policy or guidance in place but that those policies were not being followed by individual clinicians? Rather than seeking assurance of their governance and assurance processes, why didn't the Welsh Government, or you as minister, ensure that there was a review of DNACPR decisions that had been made?

A. I think that letter demonstrates that we were chasing down every case that we heard about and clearly we expect people to follow our governance and our guidance. One of the things we did was to introduce a Wales competency framework because part of the issue was just to make sure people knew what they should be doing, so we made sure that clinicians followed a competency framework so that they knew how to fill out DNACPR forms and to make sure that they did everything appropriately including, in particular, making sure that they had compassionate communication not just with the person involved but also their families.

And then the other thing that we did was to introduce a mortality review framework so -- and within that there was a thematic review in relation to DNACPR, and there was an action plan that had to be followed afterwards.

So these were kind of actions: right, here is the guidance that looks like you're not all following. This

is what we expect you to do as a result. So there was a follow-up.

Q. And who was the competency framework made available to?

A. That was to the NHS clinicians and there was a whole training programme that happened with that.

Q. The Inquiry has heard from the president or former president of the Resuscitation Council UK who had developed the ReSPECT form which is a process used in parts of England and Scotland to note advanced care plans, including DNACPR wishes of patients, and Professor Wyllie told the Inquiry that he considered it would be beneficial if there was one standard advanced care planning form which would include wishes around CPR. If there was one form in use across the UK, particularly given the amount of movement that exists between the countries of the UK, would you agree with that or do you think there are compelling reasons why Welsh patients should have a different process for recording their views?

A. I think there would be huge advantages to us having a common digital framework across the whole of the United Kingdom. We're all in different places on different things so this is not so straightforward to make that happen but in an ideal world I probably would suggest we need to try to collect data in a common way,

and, you know, if you can fill in forms in a common way then that would make sense as well. As long as we all agree with the policy. So, you know, as I suggested that we had our own clinical policy -- so, you know, you'd have to make sure that the policies were in keeping before you started to do that.

MS NIELD: Thank you very much. That's the end of that topic. I wonder if that's a suitable point.

LADY HALLETT: Perfect timing. 3.25.

(3.10 pm)

(A short break)

(3.25 pm)

LADY HALLETT: Ms Nield.

MS NIELD: Baroness Morgan, can we look, please, at the actions that you took to address problems in the ambulance sector during your time as minister. I think it's right to say there were persistent issues with excessive ambulance response times throughout 2021 and 2022 and those problems were exacerbated by staff shortages due to high absence rates and lengthy handover delays at hospital; is that correct?

A. That's correct.

Q. I think in June of 2021, so after you'd been in post for about a month, having been provided with an interim report of the ministerial Ambulance Availability

Taskforce, you requested a meeting with the Emergency Ambulance Services Committee, and you noted in that meeting that the national target for immediately life-threatening calls, red calls, had not been achieved since July of 2020, and that a move was needed -- these are your words:

"... a move was needed from review and diagnosis to radical and rapid focus on delivery of actions that are known to make a difference to patients."

And in that meeting you set out a number of expectations for the health board executives, for the Welsh Ambulance Services Trust, and for the Chief Ambulance Services Commissioner to develop a plan to address these issues. Would it be right to say that it appeared to you at this point that the ambulance committee members had been ineffective and slow to address the evident problems in ambulance response times?

A. I'm not sure if it's fair to say that I'd only been in post for a month but what I can say is that I thought the time for talking was over and it was time for action, and so that's why when they asked me if they could have a 12-month extension on the group I said: no, give me a delivery plan and close this group down and get on with the job.

So I was just responding to what I saw in front of me. I don't know what happened before.

LADY HALLETT: How refreshing.

MS NIELD: You go on to set out in your witness statement that unfortunately ambulance performance continued to decline into October of 2021, and you received, I think, a ministerial advice on 19 November 2021 requesting that you agree £5 million of additional funding to the ambulance sector, which you agreed I think on 22 November 2021. And that funding was for the recruitment of more frontline staff, clinical support desk staff, additional non-emergency transfer vehicles and support for a make-ready depot for the ambulance crews to use; is that correct?

A. That is correct.

Q. I think in addition to that £5 million that you had agreed for the Welsh Ambulance Services Trust in November of 2021, during the autumn and winter of 2021 into 2022 you were also asked to approve a series of requests for military aid to the civil authorities, MACA requests, for additional drivers to assist the Welsh Ambulance Services Trust. And I think the first of those requests came in September of 2021.

Can we have a look, please, at the ministerial advice supporting that request.

It's INQ000480061.

We can see here at point 4 that:

"... data indicates that [the Welsh Ambulance Services Trust] should increase its emergency ambulance capacity to 150% in order to meet predicted demand."

Which does not include predicted demand from seasonal flu. And:

"The Welsh Government have committed to continue with elective surgery over the winter period to meet the backlog from ... COVID-19."

I think over the page, on page 2, 251 drivers were requested at that point to drive Welsh Ambulance Services' ambulances from 15 October to 31 March 2022. That was an equivalent of an additional 42 emergency ambulance crews across the week.

And if we can go to page 3, please, in support of that request, at point 15 it's noted that:

"It is necessary to take this action to reduce patient harm and suffering as a direct consequence of delayed attendance to in-community cases/calls for emergency [ambulance] response creating significant risk to life."

And the penultimate bullet point there:

"The Welsh Government and wider public services lack the necessary capability and capacity to fulfil

the tasks. Other options, such as commercial alternatives, have been explored."

And finally:

"If action is not taken quickly there is a significant risk to life."

So, the necessity of considering this additional support was made very clear to you and the consequences of the situation continuing as it was were made very clear there.

I think it's right that, having received that advice, on 24 September 2024 the director general, Andrew Goodall, advised that rather than the 251 drivers that had been requested by WAST, just 100 drivers should be provided.

If we can go, please, to his email to you setting out that advice. He says this in the middle of that paragraph:

"Personally I feel that an offer of around 100 military personnel is more likely, more practical to be delivered would be higher than we had before, and would be equivalent in numbers to similar proposals in Scotland and NI. Costs obviously would be lower accordingly."

And I think that you accepted that advice from Andrew Goodall, and 110 drivers were provided for

a period of six weeks.

Why did you accept this advice from the director general to offer fewer than half of the requested number of drivers in the light of the very clear advice from the Welsh Ambulance Services Trust that additional capacity was required to save lives in Wales?

A. Well, that was just the first tranche, and later on we brought on about 250. So by the end of the winter period there were far more than the 110 that were first asked for.

Q. I think it's right that an additional request was made, I think on 17 November 2021, a further request for 251 drivers --

A. Yeah.

Q. -- to support the Welsh Ambulance Services Trust, and you agreed that request and you were informed, I think on 15 December, that the authorisation had been granted for the 251 drivers until the end of March of 2022.

If the original September request for 251 drivers had been granted in full, would that not have avoided the need for the second MACA request that was made in November?

A. Well, all I know is there was a 10% reduction from the first -- in terms of impact on the first 100 that we got

in. But obviously -- I think we were -- the difference is we were building up into a more intensive period so whilst in October you may need a certain number, by the time you get to February you need more, so that kind of stepping up makes sense to me.

Q. Did lack of ambulance capacity continue to be an issue throughout the third wave of the pandemic or did this seem to have solved the problem?

A. So, well, it is really difficult because -- well, first of all, there was a capacity issue and so this was going alongside the fact that I gave them 5 million extra to go and recruit more ambulance drivers, we were getting 100 new ambulance workers in but you can't switch them on, you need to train them up, so the reason why we needed these in was to prepare those new permanent ambulance workers so that was really helpful.

Part of the issue here -- it's not just all about the ambulance service, it's about things like delayed transfers of care and, you know, them sitting outside the hospitals for a long time because you can't get people through the back door, so at the same time at this was happening I was doing huge amount of work on how do you get the flow through the system. We created an extra 770 community beds that winter in order to help the flow. So you can't look at this in isolation to the

other things that were going on.

And also, don't forget, there was an issue of the number of people who were absent in terms of work from the ambulance service as well.

Q. I think you note in your witness statement that staff sickness was a persistent problem in the ambulance sector and that the ambulance workforce had markedly higher absence rates than other sectors of the healthcare workforce. Were you able to ascertain the reasons why that sector was particularly badly affected?

A. I met with the ambulance service on a monthly basis and went through these figures. I was breathing down their necks on this because I knew it would be a big issue over winter, and I asked them consistently: what are you doing about this? Why are the rates so high? And I guess some of it was because they were more exposed, they were in the vehicles with people who had Covid, and whatever. So that had an impact.

I think some of it was because they were disillusioned because they were waiting for hours on end outside so, you know, there was an issue there.

So they had to do a lot of work and it did come down but I was asking them consistently, what were they doing about it, and how were they addressing this. So, you know, they did come down, but if you look at the

numbers they were on about 13.5% sickness rates in the February. So if we hadn't had the military in, and the 100 new ambulance workers were only just coming online, it would have been really difficult.

Q. I'm asked to ask you what, if any, consideration was given to filling the gap in the ambulance service by seeking to use the independent ambulance sector who were used nationwide in England to provide support to existing NHS ambulance services in Wales. Was that a possibility?

A. Well, we did use St John Ambulance and we -- so we did, but they can't do some of the emergency work that obviously the core ambulance group can do.

Q. Thank you.

Turning now, if I may, to staff, NHS staff issues. Was there any means you were able, as minister, to gain an understanding about the impact of the pandemic on the health, including the mental health and well-being of NHS staff and healthcare workers?

A. There was. I'd just come from the role of being responsible for mental health. There was a particular focus on supporting people in the NHS and we had a whole programme of work. We put £1 million into supporting them through Health for Health Professionals support network that turned later into Canopi. So there was

definitely an awareness that they needed support and we put that support in place.

So, you know, as I say, I visited the frontline quite a lot and I was very moved and touched by it, so recognising that people needed support when they're under the kind of pressure that they were was absolutely central to the way that we needed to deal with this pandemic.

Q. In terms of risk assessments for NHS staff, workforce risk assessments, at paragraph 69 of your witness statement you refer to the September 2021 report of the First Minister's black and minority ethnic Covid-19 advisory group which set out the progress that had been made in developing the all-Wales NHS risk assessment tool.

Page 9 of that document showed that the Velindre Trust had the highest rate of risk assessing its staff, with 71% of its staff who had received a risk assessment and three other trusts, boards rather, were assessed as having over 60% compliance. Did you think that that was an acceptable level of compliance and do you think it should have been mandatory for all staff to be risk assessed by the local health board where they were employed?

A. I think the black, Asian and minority ethnic risk

assessment tool was in place before I became the health minister, so I can't speak for what was going on then but obviously, in an ideal world, you'd want everybody to have a risk assessment.

Q. Do you think it would have been more effective to ensure or to require the local health boards to risk assess all their staff and to make it mandatory rather than an optional tool that they could use if they wished to?

A. I don't know about that because I was just thinking about all of the other pressures they were under. But I think we were particularly concerned with the black, Asian and minority ethnic group because there seemed to be a much higher incidence in terms of Covid and critical care and all of those issues, so we wanted to make sure that that support was in place, particularly for those frontline workers and that they should definitely be considered in that risk assessment tool.

But I guess it depends where in the system they are. So, you know, if you're in an office the risk assessment is probably not as essential as if you're on the front line in an emergency department.

Q. From your engagement with healthcare workers during the pandemic, do you think that the Welsh Government did enough to address inequalities for black, Asian and minority ethnic healthcare workers?

A. I think the establishment of that group -- as I said, that happened before my time. There was a real sensitivity to it. It was something we discussed very frequently in Cabinet meetings. So I think -- I'm not sure what more we could have done. What we've tried to do is to build on that and now we have a very comprehensive anti-racism action plan that is following through as a result of that because it wasn't just about people in the NHS workforce, there's a broader issue in society.

Q. The Inquiry has heard that although the local health boards in Wales did record deaths of healthcare workers from Covid-19, and kept statistics on that, the Welsh Government did not request any information on it and does not know how many healthcare workers lost their lives from Covid-19 across Wales.

Sir Chris Whitty told the Inquiry that information on deaths of healthcare workers is vital information for tracking the impact of a pandemic. In retrospect, do you think Welsh Government should have been gathering the data to monitor the number of deaths of healthcare workers during the pandemic?

A. Yeah, I think we should have, yes.

Q. Finally then, lessons learned and recommendations for a future pandemic. The Inquiry has heard from the

current Director General of the Health and Social Services Group, Judith Paget, that the Welsh Government or NHS Wales has not produced one single overarching report into the pandemic response of the Welsh healthcare system as, for example, has been done within NHS England. Would it have been useful for you, do you think as health minister, to have undertaken a "lessons learned" review across the healthcare system or to pull together those pieces of work that had been done in order to reflect upon what lessons can be learned and taken forward for a future pandemic?

A. Well, we were doing a lot of lessons learned as we were going on, that's what we were trying to do, in between the various waves so that we could -- it could make a difference as things were happening. I mean, we have had a lot of reports done in terms of how we managed Covid, what could have been done better, and you're right in a sense we haven't pulled them all together. I guess this Inquiry will be very helpful in terms of pulling all those pieces together.

And one of the things that I'm really keen to do is to have that comparison, you know. It's quite difficult to make an assessment sitting in one place. I think it's really useful to have a Covid Inquiry to make those comparisons what worked well in different

places and, you know, I think the Inquiry is probably the best place to do that because we've done all of the individual reports. Now we've got to get a better sense of actually they did that better in a different part of the United Kingdom, what can we learn from that? And I'm hoping that's what we'll get from here.

Q. What do you think -- given that you said the Welsh Government or NHS Wales has undertaken a number of lessons learned review, what are the key lessons that emerge from that, in your view? What is it -- is there anything that you think should be done differently next time?

A. I think there's lots that could be done differently. The -- you need to prepare for a pandemic and you need to prepare by making sure that you reduce inequalities before you go in. It's clear that the people who suffered most, proportionately, were people who were disadvantaged and who were vulnerable before we went in. So getting rid of inequalities is -- before you get in -- you're never going to get rid of them entirely but reducing them would make sense. And we've got a strategic plan that is very focused on that. And none of that is straightforward because there's all kinds of things affect that. You know, education standards and what food you eat and all kinds of things. So,

you know, going into it fit makes sense.

You know, the state of the NHS estate is poor, so additional capital investment would be helpful.

I think for us in Wales in particular, trying to get more separation been planned care and emergency care. It's challenging, it's difficult in the kind of population base that we have, but where we have since introduced that, not just in West Wales but in that place where I found all those people not performing surgery, there's now a brand new hub that is being developed so that we can keep things separate, and then we can advance the planned care and not see that slow up in the way we did.

Our ability to change is always going to be restricted by finance though and that's the real challenge for us. And I think what was -- there were some positives. I think the digital transformation that happened as a result, really quickly, remote consultations that's been -- that's really worked for lots of people in relation to GP access. But also in secondary care, particularly in rural areas. You know, if you're a long way from a dermatologist or a -- and, you know, you can do it all online, you know, that's a lot more convenient for some people.

So I think the other thing is just to -- I think

the NHS did remarkable work, and I think the staff on the front line did remarkable work and there's a lesson there as well to empower the frontline workers I think, give them responsibility. We gave them responsibility and we empowered them with a lot of money. It's very difficult to do that in times of peace but what they did was just incredible under the circumstances, and they acted really, really quickly. And, you know, if we could bring some of that magic back now it would be wonderful.

MS NIELD: Thank you very much.

I have no further questions for you, Baroness Morgan.

LADY HALLETT: Ms Waddoup, I think you're first up. Over that way.

Questions from MS WADDOUP

MS WADDOUP: Good afternoon, Baroness Morgan. I represent the 13 Pregnancy, Baby and Parent Organisations. You have given some very clear answers already about visiting restrictions in their maternity context, for which we're very grateful. I'd like to ask you, please, about your views on neonatal visiting restrictions.

The Inquiry has heard from Chief Nursing Officer Jean White that her view in hindsight was that both parents together should always, ie from the beginning of

the pandemic, have been allowed to be with their baby on the neonatal ward.

Were you aware that Wales was the last of the four nations to direct hospitals to allow both parents to have unrestricted access to their babies on the neonatal ward, ie to treat them as one unit, as Mr Gething I think put it this morning?

A. I think Jean White is right, I think we should have introduced that earlier, and I think it's a magical time for parents and you need to allow them to be parents as soon as they can, irrespective of the circumstances. So although we may have been doing it for what we thought were the right reasons, there's a price that they've paid that they'll never get back.

Q. Thank you.

It's right, isn't it, at paragraph 258 of your statement, that the neonatal charity Bliss had been flagging this issue, making these very points to Welsh Government representatives in summer and autumn 2021. They were advocating for immediate changes to the Welsh guidance. Do you recall that?

A. I do.

Q. And it's also right, isn't it -- this is at paragraph 263 of your statement -- that it wasn't until May 2022, so almost a year later, that Welsh

guidance (a) explicitly recognised the importance of parents being treated not as visitors but as partners in care, and then (b) moved away from the more discretionary trust-by-trust approach that had been in place previously towards a more mandatory approach, essentially requiring hospitals to allow parents, both parents, to attend to their babies at the same time?

A. Yeah, we took too long. You know, I took too long to make those changes. And if I had my time again, as I say, that is one of the things I definitely would have changed.

Q. Thank you. Can you help us with the reasons for that delay? Was it, for example, due to a lack of priority being accorded to women's and maternity-related care?

A. I don't think it was because of that in particular. I think it was probably just because we were under an inordinate amount of pressure. I was still very much, you know, a very new health minister, trying to find my way through a very, very complex system. You know, I was answering a hundred -- I was making a hundred decisions every Sunday, you know, on my day off. You know, the intensity of this is something I just can't begin to describe. So, you know, it wasn't deliberate.

MS WADDOUP: Thank you very much. Those are my questions.

LADY HALLETT: Thank you very much.

Ms Jessica Jones. There you are, behind the pillar.

Questions from MS JONES

MS JONES: Baroness Morgan, I ask questions on behalf of John's Campaign, the Patients Association and Care Rights UK, all of whom are organisations representing people who draw on health and social care and their loved ones.

My first question follows on from the theme that Ms Waddoup was putting to you, the implementation of visitor guidance, and you said in your evidence that the national visiting guidance provided a baseline from which there was flexibility for local decisions to be made.

What, if anything, did you or your department do to monitor how those restrictions were implemented to ensure that local decisions to exclude or permit visitors were proportionate and adequately took into account the needs of individual patients?

A. Well, we were aware that there were differences happening around the country that were in keeping with the kind of waves of Covid and when they were happening, so people were -- some of the health boards were letting us know when they were tightening up those visiting

restrictions, so there was definitely monitoring going on in relation to that.

Q. But even in times when there were local outbreaks necessitating greater restrictions, were you aware of how decisions were being made about specific patients who may, despite the particular local circumstances, have had personal needs that required a care supporter or visitor to continue to be provided access to them, and how was that kept track of?

A. There's no way as a minister, with the kind of pressures we were under, that I could have kept track on specific patients. I think that would have been getting very much into the operational weeds. And, you know, I think you've heard earlier that my role was very much a strategic one and the guidance was set out. The operational matters is always one for the NHS itself.

Q. Thank you. My next question is about consultation with patients, and here I don't mean individual patients, but representative organisations like those for whom I act today and others in this room and elsewhere.

You've said that you would, in retrospect, have liked to have had more views feed into the decisions you made and there was difficulty in getting frontline views. But did you take any steps to try to obtain the views of patients and family organisations to consult

with them about patient experiences, of the implementation of visitor guidance, for example, and the other issues that patients were experiencing in the delivery of healthcare during the pandemic?

A. So we have an organisation called Llais, which is the formal representative body that speaks up on behalf of patients in Wales, so obviously they were feeding in regularly to policy developments, to proposals. So there's a formal structure to make that happen.

Q. And did you feel, therefore, that patient views were adequately represented in the decisions that you took?

A. I think the structure was definitely in place for that to happen. So what I can't say is whether the organisation actually truly reflected that when they were taking everything else into account.

MS JONES: Thank you very much. Those are all my questions.

LADY HALLETT: Thank you, Miss Jones.

Mr Weatherby -- he is just there.

Questions from MR WEATHERBY KC

MR WEATHERBY: Thank you.

Good afternoon, First Minister. I ask questions on behalf of the Covid-19 Bereaved Families for Justice UK group, an organisation which includes many bereaved families from Wales.

Just one topic, but an important one for those

that I represent, and it's support for bereaved families.

The NHS Wales national nosocomial Covid-19 programme identified in its March 2023 interim learning report -- I'll just give the reference for the record -- INQ000413883 at page 6.

It identified that bereavement services were extremely important to those who had lost loved ones. It identified that the provision of those services was inconsistent across Wales and therefore identified as a key learning area that bereavement support services should be proactively made available in Wales to all families who have lost loved ones and, in particular, where there's an associated patient safety incident, which would include Covid bereaved.

Can you help us, what action was taken consequent to this report to ensure that the NHS in Wales was properly providing those bereavement services and consistently so?

A. Thanks. Well, as I mentioned earlier, we did look into 18,600 or so cases in terms of who had -- people who'd got nosocomial infections and we -- that report, the national -- included a national framework for delivery of bereavement care and that was launched in 2021.

Q. Yeah.

A. And that produced then the National Bereavement Care Pathway. So that set out what should happen in the NHS throughout Wales. So that was the practical action as a result of the national framework.

Q. Well, the national framework that you reference was 2021, and is talked about in the report I've just referred to, but my question was that you had the framework, this report identified in 2023 that effectively it was being applied inconsistently across Wales. So my question was, following this report, what was done to put that right?

A. I'm not clear -- I'm not sure what was done to put that right so I'll come back to you on that.

Q. Thank you very much. That's helpful.

The second question, probably the same answer, is that the second learning point was about proactively signposting bereavement services at the earliest opportunity and my question, again, was the same. What was done about that? I assume your answer is the same, so it would be helpful if you could possibly come back to the Inquiry on that.

And, finally, about what assurance processes have been put in place on those two issues?

A. I'm just trying to -- so I've got the report in front of me which actually sets out exactly what the key learning

is, what the good practice is, and what should be done as a result, and all of that is set out in the end of programme learning report on national nosocomial.

This came out just after I'd stopped being health minister --

Q. Yes.

A. -- so I can't tell you what's happened because I'd stopped being health minister when this report came out.

Q. I won't take it any further but the reason I put the interim report to you is because that was 2023.

A. Sure.

MR WEATHERBY: I won't take it any further. Thank you.

LADY HALLETT: Thank you, Mr Weatherby.

Mr Wagner.

Mr Wagner is over there.

Questions from MR WAGNER

MR WAGNER: Good afternoon, Baroness Morgan.

My name is Adam Wagner and I ask questions on behalf of the Clinically Vulnerable Families. I want to ask you first, Baroness Morgan, about CO2 monitors. There's probably one around where you are sitting, they're sort of dotted around the Inquiry room.

Do you accept that CO2 monitors, just in broad terms, assess how well ventilation is working within

a space and therefore indicate the relative risk of something like Covid-19 spreading in the environment?

A. I remember this being an issue that was raised by the RCN during the pandemic, they were concerned about this, and one of the things we did was to -- so we did recognise that CO2 monitors had a role, but there were other things in relation to ventilation that needed to be considered and that's why what we had was an NHS specialist estates service that looked more broadly at ventilation not just at CO2 monitors.

Q. Thank you. And I'll get there in the end but can you just answer the question whether CO2 monitors in themselves assess how well ventilation is working in a room and therefore can be useful in assessing the risk that Covid-19 is spreading in the room?

A. I think there is recognition that there's a role for them but I think they're not the only mechanism of making sure that conditions are what they should be in hospitals.

Q. So it seems that you're accepting that they are a mechanism for assessing Covid-19?

A. They are a mechanism.

Q. Do you therefore accept, given that they're a mechanism which can assess the risk of Covid-19, that they're also one of the few measures, not the only measure but one of

the few measures which could be implemented which would allow clinically vulnerable people to monitor their relative safety when entering a healthcare space?

A. Well, I think it's got to be set against all of the other things that might be happening. So, you know, as I say, that Specialist Estates Services, you know, they were doing auditing, they were designing and making sure that there were alternatives, it didn't have to be all about CO2 monitoring, although they played a role also in giving advice on CO2 monitoring.

Q. Sorry, just go back to the question I was asking. Do you accept that they are a mechanism whereby clinically vulnerable people can monitor their relative safety when entering healthcare spaces?

A. Yes.

Q. Do you accept that CO2 monitors are relatively inexpensive to implement compared to redesigns of NHS estates or, you know, retrofitting of ventilation?

A. As I say, I think they're a mechanism. I think it's got to be set against all of the other things that are happening within that context but, yes, they are, relatively speaking, probably cheaper than some of the alternatives.

Q. Do you also accept that CO2 monitors would assist healthcare staff in knowing which spaces require further

ventilation or other measures such as opening windows, increasing air filtration and the like?
A. I'm not an expert on these things, I'm not an expert on what system works better than the others, that's why we've got these Specialist Estates Services to advise us on those things and what works best.
Q. So on that, at paragraph 252 of your witness statement, you refer to a March 2022 letter sent by the Royal College of Nursing requesting that you take steps to invest in the NHS estate, provide CO2 monitors and infection prevention and control nurse consultants. Your response indicated that there were no plans to provide CO2 monitors due to differing air change conditions required on individual settings and you gave similar answers in response to written questions in the Senedd on 11 March 2022. And I just want to ask you about those responses. Do you recall this?
A. Yes, vaguely.
Q. Yes. Given that you accept the CO2 monitors can be a useful tool, that they have benefits to clinically vulnerable people, and they're relatively inexpensive, why wasn't a precautionary policy of providing those monitors adopted?
A. Well, there were huge pressures on us, we had to make difficult decisions in terms of precautionary

approaches. We were generally taking a precautionary approach in Wales. This is -- was not an issue that we didn't consider. But the key thing to remember is that the Specialist Estates Services that I've mentioned were actually on a UK group that was looking at ventilation in healthcare settings and they were looking at the monitoring of use of CO2 monitoring in healthcare, so they were doing that via a UK approach.
Q. Looking back, do you think that was a bit of a missed opportunity?
A. You can't win, can you? Sometimes you say, "Why were you doing it differently?" And now you're saying, you know, "You should have done it differently". So, you know, we thought we were doing what we needed to do through getting the expert advice of NHS Wales Specialist Estates Services and we were following their advice. They're the experts.
Q. Portable air filtration systems. I think there is one next to in the Inquiry room, they're dotted around, sometimes referred to as HEPA filters. Professor Beggs, who is one of the Inquiry experts, has given evidence that those kind of systems have the potential to supplement existing ventilation systems, so sort of hardwired ventilation systems.
Do you agree that if there is a potential for

a relatively cheap method of encouraging cleaner air, and therefore lessened risk of Covid-19 circulating within hospital settings it should be properly investigated?
A. Yes, and I think that's what they were doing on that UK-wide group. I do know about air filtration systems because I was given one for Christmas. It was the most disappointing Christmas present I've ever had.
Q. Do you use it?
A. Not very often. But, you know, the reason it was bought is because I think -- my children, who were students at the time, were just about to come home and we -- and so -- and it was just -- I think it was a little bit of a "Right, let's see what we can do". But, you know, I've no idea how much it cost. As I said, it was a present and I have no idea whether it made any difference.
Q. Finally, I want to ask you about antivirals. In March 2022 the shielding programme came to an official end, and one of the matters that you relied on in making that decision was the availability of medical treatment for those at high risk from Covid-19. This is in your statement at paragraph 277. Is that a fair representation of one of the factors that was involved?

A. It was definitely a tool in our armoury, yeah.
Q. Yes. In a letter sent out by the department on 6 April 2022, responding to concerns about ending the programme, you set out information about the availability of medical treatments and antivirals available to assist in combating Covid-19 and which could assist more vulnerable groups. A number of CVF members, that's the group that I represent, report historic and ongoing difficulties in accessing antivirals within the required 5 to 7 days of infection, including difficulties of securing a referral, being positively triaged in time. Can you recall what, if any, processes you had in place to ensure prompt access to antivirals for those who were at the highest risk in Wales?
A. Yes. I remember us having quite a sophisticated operation, so we had a very comprehensive database of who were on that clinically vulnerable risk group, and if they had Covid it would trigger an alert, which means that they would get the antivirals sent to them directly. So I thought it was quite a sophisticated operation.
Q. Do you accept that if antivirals were, in fact, not practicably available for or offered to many people at higher risk from Covid-19 who became infected, they

couldn't reasonably be considered as a justification for ending shielding?
A. Yes, which is why we had a very organised system to make sure that it -- that there was a very speedy response.
MR WAGNER: Thank you, those are my questions.
LADY HALLETT: Thank you, Mr Wagner.
Ms Hannett, who's at the back there.

Questions from MS HANNETT KC

MS HANNETT: Baroness Morgan, I ask questions on behalf of the Long Covid groups.
My Lady, we're very grateful to Counsel to the Inquiry who has in fact asked and raised all the questions that we were given permission to do. May I, instead, ask permission to raise one short question with Baroness Morgan regarding the evidence that she's just given this afternoon?
LADY HALLETT: Certainly.
MS HANNETT: Thank you, my Lady.
Baroness Morgan, you gave evidence just now that just 3.5% of Long Covid patients were referred to secondary care. Isn't this extremely low figure a red flag that Long Covid patients are not receiving access to specialist clinical care?
A. I'm not an expert. That's why we had an assessment of the Adferiad programme and they didn't flag up that they

thought this was an issue.
Q. Do you agree that it maybe perhaps highlights a misconception in Wales that Long Covid is primarily about management of rehabilitation rather than a complex multi-organ disease which requires clinical management?
A. I rely on experts when it comes to how to clinically manage particular conditions and that's particularly true in relation to what is a relatively new and still not entirely understood condition.
MS HANNETT: My Lady, I'm grateful.
LADY HALLETT: Thank you, Ms Hannett.
Ms Shepherd, who is behind the pillar.

Questions from MS SHEPHERD

MS SHEPHERD: Prynhawn da, Brif Weinidog.
I ask questions on behalf of Covid-19 Bereaved Families for Justice Cymru. We have found a number of examples in this module where it appears that the Welsh Government did not subject itself to the same level of scrutiny about what went wrong during the pandemic as other nations of the UK. I've got four examples for you.
Firstly, no national investigations into cluster outbreaks in hospitals were undertaken in Wales as they were in Northern Ireland.
No pilot pulse survey akin to that which was

undertaken by Professor Fong in England took place in Wales.
The Welsh Government did not commission a look-back exercise or review to investigate into the issue of inappropriate DNACPR exercises as happened in England.
And Welsh Government did not undertake an assessment of the effectiveness of its shielding programme as Public Health Scotland and DHSC did.
Do you agree in light of those examples, there has been a failure by the Welsh Government to open itself up to scrutiny in relation to the performance of the healthcare system in Wales during the pandemic?
A. I think there's lots of things that we can learn as a result of the pandemic. This was an unprecedented situation and we were all responding to the best of our abilities with the information that we had in front of us at the time.
Are there lessons we can learn? Absolutely. I'm really hoping that this Inquiry will help us to learn some of those lessons.
No, we didn't do a national cluster exercise but we did investigate every single individual that had a nosocomial infection in our hospital, and I'm not sure if that happened across the United Kingdom.

I'm not sure what your -- I think your second point was something about pulse. I don't know -- sorry, if you could repeat that.
Q. That was the study where Professor Fong went into hospitals in England to look at what was happening on the ground as opposed to just receiving the data.
A. Ah, okay. Well, look, you've heard that, you know, I tried to do what I could as a minister within the parameters I could in the middle of a pandemic to get a better sense of what was happening on the ground.
When it comes to DNACPR, then we've had this follow-up to try and make sure that we initiate and we look at what more needs to be done in that space. And on shielding, you know, I'll be very happy to see what the Inquiry comes up with. The shielding in England stopped much earlier than ours did so, you know, it will be interesting to see what comes out of that.
But, again, we had to balance not just shielding but also, as I mentioned earlier, the other issues that arise as a result of shielding, including social isolation and mental health issues.
Q. I'm going to go on to my second topic which is data collection. Major outbreaks in hospitals were recorded via, I think it's either the ICNet or the IC Net database. To what extent did you rely on the data from

that database for policy making?
A. It's fed into the general policy-making approach.
Q. We've learned from the statement of Professor Fu-Meng Khaw from Public Health Wales that a surveillance quality assurance group was set up to feed back to the Welsh Government and health boards on any issues of data quality and completeness and for health board medical directors to feed back in turn. What was your understanding of how that database was used by the surveillance quality assurance group to monitor and respond to outbreaks in hospitals?
A. I haven't got the detail on that information.
Q. Are you aware of any deficiencies in the ICNET database?
A. I'm not aware of any issues, no.
Q. I'm going to ask, then, that INQ000327640 is brought up on the screen. I think it's at tab 52 within your bundle.

For reference, these are questions that are posed by members of CBFJ Cymru, in the one column, and the "Welsh Government Response" column is from your time in office, so it was either by yourself or someone from your office.

If we could look at page 3 of this document, in the second box down, what's said in answer to question 12 is:

"Problems were identified with the outbreak module of the ICNeT which have ... been addressed."

Are you aware of what the cause of those problems were?
A. I can't recall what the cause were, no.
Q. In which case I'll move on from this point. A concern of those who I represent is the number of cluster outbreaks in Welsh hospitals. And was that a difficulty as a result of the data collection in Wales?
A. I'm not sure if as a result of data collection. We were testing a lot of people, we were looking for it all of the time. So, you know, we know our rates were very high but we were actually looking for it, deliberately going out and making sure that we tested everybody. So that might have explained why our rates were higher.
Q. Do you agree there were gaps or deficiencies in the data recording?
A. In the middle of a pandemic it wouldn't surprise me at all if that were the case. People were being stretched left, right and centre, people on the front line who were under incredible pressure, and I'm sure there were times when data wasn't recorded at all times accurately.
Q. Did you take any steps to ensure that data on nosocomial infections could be properly collected and analysed in

Wales?
A. Well, we had a specific group whose job was to give advice on nosocomial infections, so that data piece would have been a part of that group.
Q. I'm going to move on then to the final topic, which is clean air. In March 2022 the Royal College of Nursing sent out a briefing that the spread of Covid-19 was higher in areas with poor ventilation. This in turn led to questions being asked of you about ventilation in the Senedd. Given that this had been a problem of which Welsh Government had been aware since the first wave, how was it that poor ventilation was still a problem in advance of the third wave in the winter of 2021, 2022?
A. Well, we have older hospitals. You know, we've had years of capital restriction so we haven't been able to do the kind of -- we weren't able to do the kind of individual isolation that can be done in more modern hospitals.
Q. The next topic then is HEPA filters. You spoke earlier about some of the things the Welsh Government can do to direct the health boards. Did you give any consideration to providing guidance or issuing a direction as to the use of HEPA filters in Welsh hospitals at a national level?
A. I can't remember giving any specific advice on that, no.

MS SHEPHERD: Diolch yn fawr.

Those are my questions, thank you, my Lady.
LADY HALLETT: Thank you very much, Ms Shepherd.

Thank you very much, Baroness Morgan, those are all the questions that we have for you. May I say this, that you are one of those rare beings which is a witness who answers the questions in a focused manner and a relatively short manner and at a measured pace. I can tell you that not all of us can claim such a thing. Anyway, thank you very much for your help.
A. Diolch yn fawr. Thank you.

(The witness withdrew)
LADY HALLETT: Very well, 10 o'clock tomorrow.
(4.22 pm)

(The hearing adjourned until 10.00 am on Thursday, 21 November 2024)

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